

THE PLACE OF PARANOID STATES

IN PSYCHIATRIC CLASSIFICATION

WITH SPECIAL REFERENCE TO "PARANOID SCHIZOPHRENIA"

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S E C T I O N I

INTRODUCTION

HISTORICAL NOTE

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INTRODUCTION

From early times attempts have been made to classify psychiatric material. For generations, however, the commonly accepted association of mental disease and the supernatural forbade clear thinking. It was not until the nineteenth century that real progress became apparent. This followed more exact clinical and pathological investigations and laid the basis for a rational sub-division of cases.

The subject has, however, proved a difficult one and, although a certain measure of agreement has been reached, yet not even in regard to broad groupings is opinion unanimous. Various methods of classification have been suggested depending upon psychological, physiological, aetiological and symptomatological groupings. All involve considerable speculation and assumption. Kraepelin was the master exponent of clinical psychiatry and his symptomatic classification marked a great advance. Nevertheless, this was not beyond criticism and as Macfie Campbell (1935) pointed out: "The Kraepelinian formulation seems to draw rather definite boundaries where no boundaries exist. It gives an appearance of certainty in regard to prognosis which the facts hardly warrant. The personality received scant attention/

attention; the life situation is considered to be more or less irrelevant". He goes on to say: "There seems to be no sound reason for basing the interpretation of a group of cases on a study of the more severe cases and of the later stages, unless these cases and these stages demonstrate the presence of some definite factors of unequivocal nature which, in retrospect, throw light on the earlier phases of the disorder." These remarks are directed in particular to the schizophrenic and paranoid psychoses, and it is in the classification of these states that lack of agreement is specially apparent. Whether or not patients who present predominantly paranoid symptoms should be excluded from the schizophrenic group has been described as "a problem rock on which more than a generation of psychiatrists have stranded" (Mayer-Gross and Moore, 1944)

Mapother (1921) was one who believed in the essential unity of schizophrenic and paranoid states, and spoke in terms of "the schizophrenic-paranoid series" believing the difference to be one of degree and not of kind. Thus, he wrote: "In spite of apparent diversity manifestations of the paranoid disposition probably have a common origin as secondary modes of reaction to a patient's awareness - dim or clear - of his own primary defect; viz, a certain degree of schizophrenia - the latter forms the motive of the reaction and, at the same time, determines the degree of its abnormality.

From/

"From a sense, however vague, of his own inferiority is derived a sort of distrust of both the world and himself".

In the classification adopted by "The Royal Medico-Psychological Association" the schizophrenic psychoses include paranoid schizophrenia and paraphrenia, whilst paranoia is a sub-group of psychopathic constitution. To thus separate states which are dominated by paranoid trends seems to many confusing and unjustified.

The key to a more orderly classification would seem to be the study of mental illness in relation to the personality development and the specific life situation . This involves a review of personal traits and the details of experience . By so doing common signs and patterns may be found which should materially aid case differentiation.

Such psycho-biological principles have guided Henderson and Gillespie (1946) in their formulations. Basing their classification on the Meyerian approach (1906) they speak of reaction types rather than mental diseases and separate the schizophrenic reaction types from the paranoid reaction types. Like many I am inclined to this view and prefer to divide the residue of the so-called functional or bio-genetic psychoses left after the delimitation of affective states into the above-named categories.

As a sub-group of the schizophrenic reaction type, there is described a condition generally known as paranoid schizophrenia. It appears commonly between the ages of 30 and 35 years, and is characterised by persecutory, depressive or grandiose delusions of a rather changeable and unsystematised nature, together with similar hallucinations. The course is usually considered to be a steadily progressive one involving considerable personality disintegration and general deterioration. Thus, many hold that it is but one variation of the schizophrenic process.

It has been observed that difficulties have been encountered in the past in deciding which cases presenting paranoid features were justifiably to be regarded as expressions of schizophrenia. The accurate classification of such paranoid states is of more than academic interest. It has been said that diagnosis between the various members of the schizophrenic-paranoid group is a futile proceeding, unless it involves a forecast at least in terms of statistical probabilities of recovery and terminal state (Mapother 1921). I am of the opinion that a clear understanding of such paranoid states would help towards this goal.

This investigation is carried out in an effort to decide whether or not the so-called paranoid states of schizophrenia are more closely allied to the paranoid reaction type than to the schizophrenic reaction type. A representative sample of such conditions is here examined/

examined and re-assessed.

In the past such delusional and hallucinatory psychoses have been investigated more in relation to their clinical manifestations and course. Nor is the present any exception, for we read in current literature that a group of cases of insidious onset and bad prognosis might be termed "dys-symbole" - meaning a disturbance of conceptual thinking (Skottowe 1939) and that the term dementia praecox should be used for a similar group and schizophrenia reserved for acute cases of more favourable prognosis (Darrah 1940). A new term "palaeophrenia" has been suggested to replace dementia praecox and schizophrenia, since mental testing in such states shows an impairment of conceptual thinking of a regressive nature (Osborne 1940). In this investigation the previous history and the pre-psychotic personality have been studied in addition to the clinical manifestations. By so doing, it is hoped that material will be provided which will aid in earlier and more satisfactory differential diagnosis and classification.

To clarify my conception of the schizophrenic and the paranoid reaction types, a brief description of these two broad groups seems necessary:- a schizophrenic reaction type is one or other of a series of psychotic conditions which have as their common characteristic a destruction of the inner connections of the psyche of a peculiar kind. This shows itself predominantly in a weakening/

weakening of the emotional response and in an incongruity of affect, volition and thought. Interest is increasingly withdrawn from reality and preoccupied with phantasy. Mental deterioration proceeds slowly but steadily to a terminal state which ultimately develops from varying initial clinical pictures. The course may be interrupted by remission of varying duration and degree. It may be that some recover. It is customary to describe the simple, the hebephrenic, the catatonic and the paranoid variants of this process. In the first there is a slow, insidious, almost imperceptible disintegration of the whole psychic life. The hebephrenic form exhibits characteristically profound personality devastation, gross incoherence of thought, mood and behaviour, episodes of wild excitement, delusions, and prominent hallucinations. The third is differentiated by the alternating reactions of stupor and excitement on a background of schizophrenic symptoms. The paranoid form has already been briefly described. In these conditions, although recovery and remission may take place, yet the majority proceed to an end stage of considerable mental enfeeblement.

A paranoid reaction type is one or other of a series of psychotic conditions which occurs predominantly during the third decade of life. Delusions of persecution which may later be followed by those of a more grandiose nature are outstanding. Hallucinations may or may not be present. The fixity and the development of/

of the delusions vary from those that are unchangeable and gradually elaborated by a process of logical reasoning into a coherent system, to those that are fleeting, inconstant, and poorly-systematised. The illness is insidious in its onset and in a majority of cases slowly progressive. The personality becomes transformed as a result of misinterpretation and impairment of discrimination and judgment. True remissions are not common. Personality deterioration and affective impoverishment are not prominent. Complete personality devastation is characteristically absent. It is usual to describe two variants of this paranoid process - namely, paranoia and paraphrenia. The first is a chronic, systematised delusional state of unfavourable prognosis, characterised by the fundamental unchangeableness of the delusions and the absence of hallucinations. In pure form it is uncommon. Paraphrenia is differentiated by the less well-systematised and more variable delusions, and by the presence of hallucinations.

In addition to these reaction types, two further conditions require mention. Psychoses are not uncommon in which schizophrenic symptoms are prominent. I am of the opinion that when this material is studied more closely it is found, in a great majority of cases, that the schizophrenic manifestations merely colour a clinical picture, which is primarily determined by some other cause, e.g., toxic-exhaustion. Diagnosis, management, and prognosis in these cases should be based not on/

on the schizophrenic features, but on the underlying cause. Frequently encountered also is a psychosis which has been termed abortive paranoia . It is a transient delusional state, with or without hallucinations, and with a content which is often self-acusatory. The prognosis is good, and its possible alliance to manic-depression ^{VE 876} has been stressed by many.

The differentiation of manic-depressive psychosis and involutional depression from the above-mentioned conditions is not infrequently a matter of great difficulty. Recently, the idea has been revived of amalgamating the schizophrenic and affective psychoses, using the term schizo-affective states, in the belief that they constitute the extremes of a continuous series of variables (Cobb 1941) From the statistical approach too doubts have been passed on the validity of clear differentiation between the affective and the schizophrenic and paranoid psychoses (Penrose 1946) I have been impressed by the frequency of cases presenting a mixture of manic-depressive and paranoid trends, and showing a periodicity in their clinical course. Such findings are not uncommon in the paranoid states under review, and it is hoped that the material which follows will demonstrate this association.

In conclusion, it must be freely admitted that the difficulties of early diagnosis and accurate classification in psychiatry are great . I am acutely aware of the frequent overlapping in the manifestations of the/
the/

the functional psychoses which makes attempts at precise grouping even undesirable in the present state of our knowledge. On the other hand, there may have been a tendency in recent times to neglect the careful clinical assessment and grouping of cases. This may be dependent upon an unnecessary haste to exhibit complex mental tests, electroencephalography, shock therapy, and leucotomy, which are thought to have changed the face of psychiatry. The practical danger of such an approach is clear. The results obtained in schizophrenia by insulin therapy vary enormously in different centres. Should such conditions as toxi-exhaustion, manic-depression, paranoid and psychopathic states masquerade in the guise of schizophrenia in such reported series, statistics will be worthless and psychiatric advance hindered.

In spite of all that has been accomplished previously in this field of investigation, schizophrenia remains an apparently heterogeneous group. By studying a commonly accepted sub-group from the point of view of native endowment, personality development and course - in other words, situation, reaction and final adjustment (Henderson 1916) a pattern is sought which may provide a clue to more rational classifications. Further, information may emerge which can be more satisfactorily orientated in the larger field of related knowledge.

HISTORICAL NOTE

Attempts to classify psychiatric material were made in Hippocratic times - 300 B.C.- and from then until the death of Galen - 200 A.D. - clinical observation was acute, and psychiatric thought active. Hippocrates spoke of paranoia and differentiated it from melancholia, mania and epilepsy. The term, however, now differs in meaning and was, in those times, used to connote mental deterioration. Aretaeus - 200 A.D. - sought to delimit what were apparently schizophrenic states from mania, describing patients who "fear that people wish to give them poison - develop hatred of mankind - flee into solitude.....". Of mental deterioration he wrote "It is not rare to see their sensibility and intelligence fall into such a degree of degradation that, plunged into an absolute fatuoutousness, they forget themselves - pass the remainder of their lives as brute beasts, and the habits of their bodies lose all human dignity". Such a description of what might now be regarded as the terminal state of schizophrenic deterioration can be little improved on. Hallucinated patients were also observed and described as those who "moved about thinking and seeing something else than reality, and expressing themselves in terms of strange visions (Zilboorg and Henry - 1941)

The death of Galen ended this era of psychiatric wisdom, and for the next sixteen centuries demonology dominated all conceptions of mental illness. The beginning/

beginning of the nineteenth century marked a revival of interest in the so-called functional mental disorders. The approach again became Hippocratic and observations were directed particularly to the form, course, and outcome of the psychosis. Heinroth (1773 - 1843) was of the opinion that established delusions of persecution or grandeur depended primarily on a disorder of the intellect. Griesinger (1845) on the other hand thought that such disorders arose on a basis of emotional disturbance and as a sequel to affective conditions. The term paranoia was re-introduced by Kahlbaum (1863) and used to describe a group of delusional hallucinatory states which he considered to be essentially intellectual disorders. For a further group he suggested the term paraphrenia (1912). Kraft-Ebing (1840 - 1903) followed Kahlbaum and believed that delusions arose independently of affective disturbances. He noted the predisposing personality, and considered that the retiring, solitary and suspicious tended to develop persecutory delusions; the excitable and self-centred - delusions of a grandiose character; and the eccentric and over-conscientious, abnormal religious ideas. About the same time Magnan named such states "délire chronique à évolution systématique" and described its course as being of four stages - namely, hypochondriasis, - persecution, grandeur, and deterioration, in that order.

In this vast, ill-defined, and seemingly mixed group of psychotic disorder there was described a rather characteristic and commonly recurring clinical picture with its maximum incidence in the second and third decades of life. To such states Clouston (1898) applied the term adolescent insanity, without attempting to differentiate clearly therefrom the early occurring affective disorders.

At the close of the Nineteenth century -(1896)- Kraepelin (1855 - 1926) led what has been called the Static School of Psychiatry and formally classified mental and nervous disorders. He felt that there was a natural law governing mental disease; that it was predetermined, and that some naturally recovered, while others naturally failed to recover. He went further, and said that not only was the outcome predetermined but the course also. In fact, diagnosis was based on prognosis. Such a conception has been criticised as a departure from sound principle in general medicine, since "one cannot say that because a disease ends in a certain definite way, it is a certain definite disease" (Zilboorg and Henry) - 1941) Nevertheless, Kraepelin made an outstanding contribution to psychiatry, and his clinical descriptions are probably unsurpassed.

First, he separated from this ill-defined psychotic material the manic-depressive states. This was a distinction of great importance, particularly in respect of prognosis which was favourable in manic-depression and /

and less favourable in the remainder. Having made this differentiation, he divided the residue into three groups, namely, dementia praecox, paraphrenia, and paranoia. Dementia praecox was a term first introduced by Morel in 1860, and was probably synonymous with Clouston's secondary dementia of adolescence. It was held to account for one-eighth of admissions to mental hospitals. Its initial symptoms became manifest at the adolescent period, and the disease was thought to progress usually to a terminal stage of dementia. Four variants were described - the simple, the catatonic, the hebephrenic, and the paranoid forms.

Kraepelin admitted that this attempt to so classify these states was a tentative one based principally on the course of the illness. Thus, he thought that 40% of them ultimately reached a stage in which they presented the characteristic terminal manifestations of dementia praecox. The paraphrenias constituted a larger group which showed greater personality retention. A small residue he believed to be the real paranoias, showing throughout little personality deterioration and characterised by the fixity of their delusions, and the absence of hallucinations.

There were, however, psychiatrists who held the view that dementia praecox, implying as it did, a rather hopeless prognosis was an unfortunate term. It became increasingly clear that neither a terminal state of dementia nor an onset in adolescence were essential features/

features of the disorder. Although it was true that Kraepelin's conception of steady deterioration to a stage of mental enfeeblement of a characteristic kind was observed in a majority of cases, yet improvement or cessation of symptoms was also found.

It was in 1911 that Bleuler approached functional mental disease from the psychological angle and introduced the term schizophrenia (Bleuler - 1923). In his explanations he utilised the psycho-analytic theory and psychological association. He suggested that the basic symptoms of the disease were dependent upon a psychological loosening of associations, and stressed the importance of autistic, dereistic, and phantasy thinking. The clinical pictures described by Kraepelin he thought to be secondarily determined and not specific.

Bleuler believed that all such conditions as dementia praecox, paranoid states, paranoia, and hallucinoses were but varying manifestations of one underlying disease process. The splitting of the intrapsychic life, as he conceived it, did not necessarily end in dementia, and might arise in adult life. He believed that for all there was a common constitutional predisposition. Such a comprehensive term allowed of widely varying prognoses in those so afflicted. Thus, he believed that many paranoids recovered before they reached full development. In relation to Kraepelin's paraphrenic groups Bleuler thought that its differentiation from paranoia on the one hand and the paranoid forms/

forms of dementia praecox on the other was scarcely possible. He doubted if hard and fast lines of delimitation on a basis of clinical manifestations was practicable. The term schizophrenia, although used by some in a rather more restricted sense than originally defined, has tended to supersede dementia praecox, and is now in common use.

It has been said of differential diagnosis that it is both the most important and the most difficult aspect of general medicine. It is certainly a most difficult aspect of psychiatry, but of its importance opinion is divided. It can readily be seen that within the group outlined above are psychoses of varying manifestation and prognosis, but that similarity and overlapping of syndromes make clear separation impossible. It seems that Kraepelin, in an effort to understand these states, attempted to sub-divide them more finely than the facts allow.

Some have preferred to follow Bleuler more closely. Mapother wrote of the schizophrenic-paranoid series, believing the psychoses classified within these categories to form a continuously graded series. He thought the adoption of some term comparable to manic-depressive psychosis would emphasise the essential unity of the series and do much to clarify psychiatry. Since certain current schools of psychiatric thought are of the same mind (Gordon, Harris and Rees - 1936; and in addition Curran and Guttman - 1943) a closer examination/

examination of this conception may be of value .

He held that such states were characterised by intermixture in varying measure of three anomalies of habitual reaction, viz., introversion, schizophrenia, and paranoid disposition. By introversion he meant a generalised diminution of response to external impressions and, particularly, the affective response to such. Of schizophrenia he wrote "Logical thought, appropriate feeling, and expedient action are dependent on a conscious synthesis of present impressions, past experience, and future aims. In schizophrenia there is a reduction of the tendency to comprehensive and selective synthesis - intra-psychic ataxia - there is no constellatory influence of one dominant feeling - splitting of the mind occurs, resulting in mental processes which are not connected by conscious links with the rest of the patient's thoughts and actions. Thoughts, feelings, and actions become devoid of intelligible sequence." The paranoid disposition, he thought, was a secondary reaction to an awareness of schizophrenia.

Freud made a **contribution** to the elucidation of such states and stressed latent homosexuality as a determining factor in schizophrenia and, particularly, in the paranoid form(1925)

Fifteen years after Kraepelin's statement of a definite disease - dementia praecox - a new concept appeared/

appeared which threw fresh light on this difficult subject. This followed the work of Adolf Meyer (Meyer 1906 and 1910) Meyer was a dominant figure in American psychiatry. He did not accept psychoanalysis, nor did he agree with Bleuler's views. Sharply defined borders for the classification of mental disease had no appeal for him. He held that a clear understanding of such states could only be derived from a study of the total personality reaction. He stressed the importance of a psycho-biological approach, a concept based on a genetic-dynamic understanding of patient and illness. Within such a general framework genetic, congenital, physical, and psychological factors all received consideration. He believed that under the stresses of life a series of unhealthy reaction patterns might be developed, the cumulative effect of which might be psychological illness. Hoch (1913) who followed Meyer's lead studied the pre-psychotic personalities of a series of cases of dementia praecox, and found that certain character traits regularly recurred. Thus, psycho-biologists believe that in such a genetic-dynamic method of study the life record and the life experience alone can supply the understanding. - "We are studying living men - not yet dead - and man is an experience-conditioned, life-record determined creature" (Terry and Rennie) - 1938)

In this suggested scheme of classification Henderson and Gillespie follow Meyer and speak of reaction/

reaction types instead of mental diseases , thus concentrating attention upon a psycho-biological approach. They divide the material under review into the schizophrenic and the paranoid reaction types. The former category included until recently (1945) the four sub-groups described by Kraepelin; namely, the simple, the hebephrenic, the catatonic, and the paranoid. In relation to these they described the shy, withdrawn, a-social, dreamy personality types and consider that in the majority of cases the course is a slowly progressive one to an end stage of personality deterioration of a characteristic kind. They believe, however, that some cases show remission of variable duration, some come to a standstill before the terminal stage, and some apparently clear up completely. Included in the latter category are Kraepelin's paraphrenias and paranoidias. The associated pre-psychotic personality is of a sensitive, suspicious type which tends to develop unreasonable but strong central convictions, on the basis of which ideas are elaborated which misrepresent reality. The prognosis in a well-established case they believe to be uniformly poor and they consider remissions exceptional. They are, however, impressed by the striking absence of personality deterioration. So well is this retained that in many maladaptation is never of such a degree as to make entry into a mental hospital necessary. This classification has many adherents, and I believe it has materially helped/

helped to clarify the apparent polymorphism of this group.

The place of paranoid states has long been a problem. Kraepelin was always in some doubt about his classification of this form of mental disorder, yet he felt he was probably justified in regarding it as a manifestation of schizophrenia. He even attempted to sub-divide it still further into the mitis and the gravis types, the former being characterised by delusions and hallucinations without profound disintegration of the personality, the latter being a disorder of middle and later life with a similar initial clinical picture but with a course which embraced the usual terminal schizophrenic phenomena.

On this subject Henderson and Gillespie have recently altered their views (1946) and the following extract indicates their present conception: "The section on paranoid states has been moved from the schizophrenic reaction type to that on the paranoiac and paranoid reaction types, thus altering the classification of schizophrenic states or dementia praecox as formulated by Kraepelin. Our experience has led us to the view that the states described as paranoid forms of schizophrenia are much more closely allied to the paranoid reaction types than they are to other forms of schizophrenia. This similarity affects both symptoms and prognosis and, in consequence, we feel that the undergraduate studying such conditions will get a better idea of the whole paranoid/

paranoid reaction type when it is considered in the way we now suggest".

They point out that delusional states occur in schizophrenia but they also occur in manic-depressive psychosis, involutional depression, and organic brain disease. They believe that the crux of the situation from the standpoint of differential diagnosis is determined by the underlying type of personality. While admitting the difficulty of exact differentiation of pre-psychotic personality types, they believe that certain traits stand out more prominently in some than in others and that on a basis of careful personality study pointers may be found to indicate correct diagnosis.

It is of interest to note that White (1936) from an examination of similar material was disposed to separate all paranoid states from the schizophrenic group. He concluded that there were all degrees of paranoid reaction from the point of view of course and outcome in deterioration.

This brief historical survey is necessarily incomplete, for a vast and rather confusing literature has accumulated on the subject . It has not been possible to do more than outline some of the outstanding contributions. Yet an effort has been made to indicate the trends which have moulded current thought and such a familiarity with what has already been accomplished enables one to grasp more clearly its implications and direction, and to recognise the gaps which must be closed to/

to provide a clearer understanding of such conditions. In regard to paranoid states the gap would seem to be dependent , in part at least, on an over-emphasis of the clinical manifestations and course at the expense of a study of the personality and the specific life situation.

COMPARISON OF SCHIZOPHRENIC AND PARANOID REACTION TYPES

As a prelude to the presentation of the clinical material it may be of value to compare and contrast briefly the schizophrenic and paranoid reaction types. By so elaborating the description already given, points on which differentiation may be made can be stressed. In the light of this the cases which follow may be more satisfactorily examined and classified.

THE AETIOLOGY:- The number of theories suggested to explain the cause of these psychoses makes clear our inadequate knowledge in this direction. The constitutional, the psychological, and the organic approach have all their followers. More recently, complex investigations of metabolism and autonomic function have raised fresh hopes of a clearer understanding. Nevertheless, if specific agencies are involved, they have so far eluded research, and many prefer to steer a middle course, accepting the part responsibility of all the above-mentioned factors. Inheritance is of significance and many consider it the most important single agent. A family history of mental illness is to be found in approximately half of such cases. Bleuler believed these states to be dependent on the constitution and ascribed significance to complexes and psychological influences only for the colour they added to the clinical picture. Kraepelin was inclined to the view that endocrine disorder led to autointoxication, with resulting/

resulting injury to the cerebral neurons. Mott (1919) supported the organic theory and described pathological changes in the brain and gonads. More recently, Hemphill (1944) with testicular biopsies has revived interest along these lines. Jung postulated the importance of the complex, meaning a system of wholly unconscious ideas living a parasitic existence in the mind, and monopolising an undue amount of mental energy. In regard to the importance of remote experiences, Mapother (1921) felt that these were rather descriptions of the earliest manifestations than attempts really to account for the disease. He doubted if the introvert disposition could be ascribed to such experiences, and preferred to regard it as possibly the psychological equivalent to inherent defect of those cortical neurons whose function is adjustment to new and exceptional situations. Innate sensitiveness, he felt, might be a subjective awareness of such defect. Thus, opinion is divided as to how far particular circumstances of life may provide factors of major causative importance. Meyer, however, was in no doubt as to the significance of the specific life situation in the ultimate production of such states.

Thus, although the exact aetiology remains obscure, yet the theory of multiple causation which emphasises the importance of the personality and the total experience, seems at the same time the most rational approach and that most likely to provide a practical basis for the differentiation of these states.

THE PERSONALITY:- In regard to schizophrenia Kraepelin was concerned essentially with the description and the course of the disorder. Yet he was not unaware of the usual pre-psychotic personality. He describes such persons as being quiet, shy, retiring, nervous and irritable, as **patterns** of goodness - aloof from naughtiness - and as those who tended to live only for themselves. Hoch (1913) emphasised the shut-in personality with its reticence and seclusiveness, its **stubbornness** and lack of interest. Meyer considered the soil to be characterised by hyper-sensitiveness, instability of temperament, poor initiative, day-dreaminess, evasiveness, and want of aggression. Bleuler wrote that in cases which from childhood upwards had exhibited abnormal traits, the prognosis was more unfavourable. It seems therefore that those are most predisposed who have from an early age presented neurotic symptoms - excessive shyness, backwardness, lack of ambition, idiosyncracies, and perversities, and oddities of behaviour and who, during their lives, have lacked the ability to adapt themselves to society, and to undertake any satisfying and useful activity, with increasing feelings of inadequacy and insecurity. Such persons may slowly and insidiously in the course of months or years develop the abnormal reactions to life which are termed schizophrenic.

The personality in the paranoid reaction types is/

is rather different. In some the pre-psychotic state has shown little deviation from the normal. Not infrequently the school and work records are entirely satisfactory. In their respective walks of life many have performed their duties diligently and conscientiously, with the attainment of considerable success. Nevertheless, the majority are touchy, asocial, and ill-adaptive. Hyper-sensitivity and suspiciousmindedness are common features. Many case histories indicate an overweening pride and ambition. They are those who tend to be over-anxious, irritable, and continually on the defensive in their social relations. Psychoanalysts are convinced of the major significance of latent homosexual trends. These are common, but not invariable. Meyer describes the personality as one which is continually ready to see a biased meaning in things, always wondering what other people think, and attributing deliberate intentions to the indifferent actions of their neighbours. They read more into situations than is really there, so that innocent circumstances come to be falsely interpreted. They find life difficult and try to impress upon others that they are ill-fated. Over-determined ideas ill-founded in fact easily dominate them. The stage thus set, it is but a short step to the formation of paranoid delusions. Thus White (1936) believes that we see paranoid states running all the way from the over-suspicious man, who is however competent and comparative-ly/

comparatively well-adjusted to the pure paranoia, on the one hand, and to the more involved paranoid states on the other.

THE PSYCHOPATHOLOGY:- Kraepelin described the schizophrenic process as a peculiar destruction of the **psychic** personality, leading to a loss of unity in thought, feeling and action. Jung emphasised the importance of mental conflict in producing the strange and senseless behaviour of the schizophrenic. Most theories of psychopathology are but variants of the same theme. The individual, for some reason, finds life too difficult, and turns away from it. Occupation with hard reality becomes preoccupation with phantasy. The intra-psychic balance and cohesion, necessitated and maintained by contact with reality, becomes replaced by disharmony. This results in a splintering of the mind with the release of personal traits and complexes which find expression in bizarre behaviour and strange disconnected thoughts. Withdrawal of healthy emotional response accompanies the submissive retreat and results in the grossly inadequate affect which is so striking. Henderson and Gillespie have pointed out that the personality is the product of the instinctive forces and the environment. If the environmental demands are reduced, the instinctive forces predominate and are allowed free and unlimited expression. The personality becomes altered and socially deteriorated/

deteriorated. Thought and action become dominated by loosely-connected complexes. Mapother, using the concept of levels in the nervous system, puts it this way - there is a depression of activity at the highest level resulting in incoordinate activity at lower levels. This results in replacement of adequate synthesis of all present and past experience by less complex reactions of thought and action and of emotional associations formed in the distant past. Whatever the process, it results in a loosening and disintegration of personality structure.

In regard to the paranoid reaction types it has been suggested that on account of morbid heredity and unsatisfactory early environment, there is a defect of personality development, and adjustment to life is found impossible. Such people, however, are too well-integrated mentally to collapse and deteriorate as do those who develop schizophrenia. Rather do they tend to compensate for their deficiency by the erection of delusional systems. Thus, White considers that the pathology of these states is the pathology of the constitutional background upon which the paranoid mechanisms are built. Morbid projection, over-compensation for feelings of inferiority, and false rationalisations are outstanding features. The patient possesses the very traits he denounces in others. He considers everyone wrong except himself. He falsely interprets innocent circumstances and, by twisting/

twisting and distorting the facts, decides that sinister agents are at work against him. He reviews the past in the light of his present morbid affect, and his memories become falsified so that only those aspects are recalled which confirm his present ideas. Henderson and Gillespie have pointed to the great importance of complexes with strong affective value and to the role of inferiority and guilt feelings. Regarding the secondary elaboration of delusional trends they suggest that the affect of the original complex continues to operate and that flattering rationalisations result from compensatory superiority feelings.

THE SYMPTOMS:- The emotional reaction in schizophrenia has been described in this way: "When patients in spite of complete understanding show no further interest at all in their fellow-patients, their relatives, or their occupation and accept indifferently threats and contradictions regarding their delusions, can we conclude real annihilation of emotion. Their hopes, wishes, cares and anxieties are silent. Their moral sentiments suffer, loss of sympathy results in indifference, delicacy of feeling completely disappears and, with the weakening of the emotional activities which form the mainsprings of volition, the link connecting rational action with perception and thought vanishes." This statement of Kraepelin's indicates clearly the emotional disorder found in these states. In well-established cases the patient's/

patient's whole attitude to life becomes one of apathy and indifference. Thus, he seems completely severed from his environment, and situations which normally evoke intense feeling leave him unmoved and unconcerned. To establish rapport with such emotionless personalities is a matter of the greatest difficulty, and the impression gained is that there exists an impenetrable barrier between doctor and patient. This grossly inadequate emotional reaction, quite inconsistent as it is with the thoughts and behaviour, constitutes perhaps the most striking feature of this state. Tredgold (1943) has suggested that the fundamental abnormality may be a defect of the conative functions of the mind - a lack of desire, ambition, and mental aggressiveness; a shallowness of feeling and a weakness of will, which produce a withdrawal of interest and a pre-occupation with thought.

In contrast, the emotional response in the paranoid reaction types is strong and adequate and remains retained at a comparatively good level throughout the course of the disease. Further, it is for the most part consistent with the trend of thought and the behaviour.

Apathy and indifference are strikingly absent from the clinical picture.

In the schizophrenic reaction type the mental trend is secondarily determined by the primary anomalies. Thus, the affective impoverishment with its indifference and/

and apathy, its incongruity between mood and thought, and its episodic abnormalities of attitude and behaviour constitute a background of intra-psychic fragmentation upon which the hallucinations and delusions arise. To quote Kraepelin, such patients are subject to strange thoughts which seem not to belong to them, and which seem to have been withdrawn from the dominion of their will. Delusions of reference, influence, sin, grandeur and sex may all appear, but are inconstant and changeable and commonly bizarre and fantastic. In time, the stream of mental activity suffers considerably, and by an apparent defect in thought association and control great incoherence and disconnection of speech become manifest.

In the paranoid reaction types, on the other hand, paranoid delusions introduce the clinical picture and dominate it throughout. A prevailing suspiciousness in a hypersensitive personality passes easily through ideas of reference to delusions of persecution. These become built up into unshakable systems. Further expansion may be logical enough, or less probable and more bizarre notions may evolve. Hallucinations may be present. In many cases the thinking, apart from the delusional regions, is of a logical and orderly type. In others, the mental involvement goes deeper but the gross disconnection and incoherence of the schizophrenic is never seen.

THE COURSE:- A schizophrenic reaction type, once started, implies at one extreme an insidious process of slow progression which strikes deeply, producing profound changes in all aspects of the personality, and, at the other, a rapid course of mental deterioration. Remissions may occur, especially in the catatonic form; improvement in remission is variable. Thus, there may be constraint of manner, lack of clear insight, emotional dullness, or poverty of thought. It seems generally agreed that in some cases recovery takes place, although the yardstick by which it is measured is difficult to standardise. A further group shows social recovery. In the majority of cases, however, an apparently irrecoverable illness proceeds with considerable mental deterioration, and with the appearance of such behaviour disorders as mannerisms, stereotypes, automatic obedience, negativism, rhythmical movements, and degradation of habits. Such patients are for the most part completely uninterested in what is going on around them and, although they may perceive happenings, they apparently make no effort to follow, retain or reproduce what they see.

The paranoid reaction type, once established, tends to run a prolonged course and, on the whole, the prognosis in respect of full recovery is poor. Remissions are not common. Henderson and Gillespie have pointed out that a small minority of those entering mental hospitals make a sufficient re-adjustment to enable/

enable them to leave hospital. Some may lead useful lives, and some may never become sufficiently ill-adapted for them to enter mental hospitals. It seems best not to differentiate too finely between the chronic systematised delusional states and the more loosely-connected delusional hallucinatory forms. In the purer types, as the course proceeds, the personality remains intact and harmony between thought, affect and behaviour is maintained. Their responses and reactions fall within the limits of normal, except when their delusional beliefs are touched upon. In the less pure forms, delusions are at all times prominent, but they are variable and poorly-systematised. Nevertheless, the dullness and indifference and the alterations in disposition which characterise the schizophrenic process are absent. As the condition progresses, a predominantly persecutory picture may be replaced by megalomania. Retention of the personality and absence of deterioration are found after illnesses of twenty to thirty years' duration.

S E C T I O N I I

PRESENTATION AND DISCUSSION OF FOUR CASES

TABULATED EXTRACTS OF INFORMATION FROM ALL TWELVE CASES

GENERAL DISCUSSION

SUMMARY AND CONCLUSIONS

PRESENTATION AND DISCUSSION OF FOUR CASES

This investigation was carried out at the Royal Edinburgh Hospital for Nervous and Mental Disorders between the years 1943 - 1946. Opportunities were there available for examining and observing large numbers of cases corresponding to the schizophrenic and the paranoid reaction types and, in addition, a large number of case records of these disorders was available.

Twelve cases are here presented of the paranoid states under review. All of these have been personally examined and managed but, in addition, they have been examined by others and have been variously designated "Paranoid State" "Paranoid Schizophrenia" "Paranoid Reaction" or simply "Schizophrenia".

To avoid lengthy repetition of case records in this section, which might become tedious to the reader, four cases only are here presented and discussed. The remaining eight cases are detailed in the Appendix. In the Tables and General Discussion relevant material from all twelve cases is incorporated.

The age noted at the beginning of each case history is that on which definite symptoms first appeared.

CASE NO. IS U M M A R Y

This patient was a sensitive, suspicious and jealous man who, in his late twenties, gradually became asocial, irritable and depressed. Ideas of reference and delusions of persecution were expressed together with thoughts of unworthiness. He attempted to gas himself and his children - one child died. He was indicted on a charge of murder and attempted murder, but was deemed insane and unfit to plead. After eleven years detention he came under the writer's care. Paranoid ideas persisted. There was apparent depression, and yet a facile smile was noticeable. The stream of talk was rational and to the point. There was little to suggest mental deterioration, and the personality was surprisingly well retained.

C A S E H I S T O R Y

L. R. - aet 28: The patient was an illegitimate child. His Mother became insane five months after his birth and entered a Mental Hospital. A diagnosis of adolescent insanity was made. She was described as a healthy, well-built Orcadian woman who was dull, confused, and unresponsive although quiet and manageable. While in the Ward she used to sit with hanging head, apparently withdrawn from her environment. After eight months she became irritable, impulsive and assaultive. After eighteen months - apparently on impulse - she threw herself out of a window and died instantaneously from a fractured skull.

The patient never knew his Father. He was brought up by his Grandparents, who treated him well. There were no nervous traits in early childhood. He attended school from 5 to 14 years. He was an average scholar, who was quiet, reserved and conscientious. He had several friends and no abnormal features were noticed. He was employed first as a Farm-servant, but at the age of 17 years he took up ship salvage work. He worked steadily at this for two years, at which time he left Orkney and came to Fife in search of better wages and prospects. He obtained work with a Ship-building Company, and for the next nine years, he worked steadily at this job. He was a conscientious, hard-working man and others confirm his industry and proficiency in this direction.

In 1928, at the age of 22, he became friendly with a girl. She became pregnant to him and he married her. Six months later his first child was born. A second child was born two and a half years later. For a period the married life seemed satisfactory, but in the course of time his Wife noticed a coldness in his attitude towards her. He refused to share the same bedroom and all sexual relations were discontinued. He became quiet, read a great deal, and spoke little to his Wife. He disliked people coming to the house, and scarcely spoke to visitors. He brooded and seemed pre-occupied. Edgar Wallace was his favourite Author. He slept/

slept and ate well and was at all times considered an excellent worker.

His Wife described his personality traits thus: He gave the impression of having little real affection for her, although he seemed to like his children. He was sensitive and shy and modest about many things, yet he was also conceited - particularly regarding his personal appearance. He took offence easily and his Wife had to be careful of what she said to him. He was stubborn and quick-tempered, jealous and suspicious. He was particularly suspicious of his Wife and often and unjustly accused her of infidelity. There were many rows, he swore at her and struck her, so that she many times sustained bruises. On one occasion he caught her by the throat. He disapproved of the fact that his Wife became rather stout after the birth of her children and seemed ashamed of her. He was extremely careful of his personal appearance and fussy about the cleanliness and orderliness of his house. On occasions, when his Wife was harrassed and omitted to set the table properly, this precipitated him into a wrath. Miserliness was another of his characteristics, and it is said that he would have allowed the family to starve as long as he could save. He tended to be moody and uncommunicative, but there were times when he was bright and cheerful and easy to get on with.

At the age of 28 years he began to react in a peculiar/

peculiar way. He seemed intensely nervous. He was restless and unable to relax. He became increasingly suspicious-minded and formed the impression that people were looking strangely at him, and speaking about him. He then suggested that his Wife might want her freedom, and expressed ideas of unworthiness. He told his Wife of his persecutory ideas, but she was unable to reassure him. One day he told her his fellow-workmen were accusing him of having sexual relations with men. Sleeplessness and agitation followed; he lay turning and twisting in bed and spoke of suicide.

One morning he seemed so distressed that his Wife became worried and went to call the doctor. When she returned she found the patient had interfered in some way with the gas meter. Both he and the two children were unconscious. One child died - the patient and the other child recovered. He left a letter saying he was taking the children with him and leaving his Wife free. He was charged with murder and attempted murder, but was deemed unfit to plead - medical evidence affirming that he was suffering from depression and delusive persecutory ideas. He was committed to H.M. Criminal Mental Hospital.

During the first year there he was very depressed, sleepless and difficult to manage. After a year the clinical picture altered, and for several months he showed elation with manic symptoms. Thereafter he became quiet and co-operative, but seemed to lack/

lack insight into his mental disturbance. He was employed on indoor domestic duties, and showed no signs of any mental deterioration.

In 1943 he was transferred to a County Mental Hospital and was reported as being quiet, seclusive and introspective. He did not mix to any great extent with others, nor did he converse readily. When addressed, his replies were rational and relevant, but he was disinclined to talk of his former difficulties, appearing to have little understanding of what he had passed through. His intellect was average and did not seem to have deteriorated in any way. Outwardly he appeared mildly depressed, and there was a suspiciousness in his attitude - he was guarded in what he said. He was an excellent worker and in this direction was most co-operative.

His Wife has visited him regularly, and says she has been faithful to him throughout these years, yet he has been difficult and stubborn with her on these occasions, and she formed the impression that he did not have much love for her.

When the writer first met him in 1945 his mental state was approximately as described above. He kept to himself. He said he was happy enough in so far as one could be happy under Mental Hospital conditions. He was most anxious to be given his freedom after twelve years confinement. He answered shortly and only in response to direct questioning and, although he/

he talked more freely as the conversation proceeded, yet there was always a reticence and an absence of complete rapport. He said he was sensitive and that his fellow patients might know of his record and not want to talk with him. Paranoid trends persisted and he still maintained that his mates were acting strangely towards him at the time of his suicidal attempt.

He said that were he allowed his freedom he would go his own way and did not much care if he lived with his wife or not. There was a shallowness in his emotional response in this connection which had impressed itself upon her during her visits. He appeared depressed, and yet there was a smile that played about his lips giving the impression of a degree of facility and incongruity.

His intellectual faculties were intact. He continued to take a pride in his appearance. His general behaviour showed no regressive characteristics, and his personality is retained at a very good level after an illness of at least twelve years' duration.

He is described by the Head Gardener as a most competent and reliable workman.

Throughout his illness he has been carefully examined physically on several occasions with negative results. He is a man of average size and good general physique.

DISCUSSION

After an illness of twelve years' duration this patient continues to have delusions of reference and persecution. He adopts an attitude of superiority to others and, for the most part, remains aloof. He is suggestible and frequently, in the course of conversation, a smile plays around his lips in a facile way, suggesting a degree of independence of thought and mood. His behaviour is correct; he is an excellent gardener and undertakes skilled jobs without supervision. He has certain privileges which he has never abused. About his personal appearance he is particular, and is always well-groomed. His talk shows little that is abnormal, and when confidence is established he relates his past and present difficulties. Yet, an attitude of suspicion prevails and becomes more pronounced in the company of strangers, so that it is with difficulty that information can be elicited from him. The occasional impression of facility gained from his facial expression and this disinclination to speak suggest to those less well-acquainted with him a state of apathy and indifference, which is not borne out by more careful scrutiny. The slight affective blunting and incongruity have been noted but, for the most part, the personality is well integrated and there is little to suggest mental decline. The emotionless, apathetic, deteriorated picture so frequent in Schizophrenia of long standing is here conspicuously absent.

The/

The clinical picture was ushered in at the age of 28 years with paranoid symptoms. Initially, there was a strong depressive component. The striking feature is the well-retained personality after the lapse of twelve years. An examination of the personality structure, and the details of experience reveal significant material. The patient was illegitimate. Five months after his birth she became mentally involved and committed suicide in a mental hospital some months later. There was thus separation from the mother in early life and there was no father. He was a quiet, reserved, and conscientious child and later became an efficient and industrious workman. Paranoid traits came to dominate his personality in which there were also strong obsessional trends and a tendency to affective lability. During the first eighteen months of his illness the disorder of mood was prominent, and both depressive and manic phases appeared. Thereafter, the paranoid symptoms continued to dominate the clinical picture throughout its course.

To write in terms of psychopathology is, at best, to speculate reasonably of cause and effect. The family history may indicate predisposition. The knowledge of illegitimacy and the absence of parental example may have produced feelings of inferiority and inadequacy mirrored in childhood reserve. The adult paranoid-obsessive personality may be in part determined by the basic genetic equipment and in part compensation for/

feelings of humbleness and insecurity, derived from the constitution and early environment. With such a sensitive, conceited, jealous and obsessional character - ever ready to misinterpret, insinuate, and accuse, the scene is set for further and more grave developments. Marital disharmony was the first indication of difficulty in social adaptation. The marriage was not wholly of choice, the first child being born six months later. Under other circumstances, he may have remained single. The jealousy and suspicion seem projections of his own failings. Psychoanalysts have stressed the strong homosexual component of the paranoid make-up. The miserliness and meticulousness further indicate such abnormal trends. There developed an emotional indifference towards the wife. Such heterosexual maladjustment may have produced further regression to the homosexual level which was inadequately repressed and resulted in projection, so maintaining the internal equilibrium at the price of psychotic development. The nature of the persecutory delusions - that the patient was having intercourse with other men - would seem to confirm these speculations. About the same time as the delusive developments, there was an alteration of mood with tension, agitation, depression, and ideas of unworthiness. The prominent affective disorder in the early stages exemplifies what was stressed by earlier writers and the association of affective and paranoid symptoms has been already mentioned.

Thus/

Thus, it may be that faced with an intolerable life situation such a personality reacted by misinterpreting reality. The personality was such, however, that its cohesiveness and the stability of its integration disallowed of a total collapse and retreat, so that after twelve years of mental illness it remains well-retained.

CASE NO. II
S U M M A R Y

The patient was an intelligent, proud and self-opinionated woman, who had managed to handle her problems at a satisfactory level until the age of 33 years, despite the fact that she had, during her life, involved herself in a series of unfortunate situations. At this time she became mentally involved and, on admission to hospital, two years later, she expressed a variety of delusional ideas of a bizarre quality, together with similar and prominent hallucinations. There was a depressive component to her illness. After three years of mental involvement, her personality was well-retained. Occasionally, there was evidence of incongruity of affect but, for the most part, the emotional response was appropriate. In addition to persecutory delusions, there were expansive developments. Her symptoms showed a certain periodicity.

CASE HISTORY

M. McD. - aet 33:- The Paternal Grandfather suffered from loss of memory, apparently determined by senility. The Father committed suicide at the age of 53 while in a Mental Hospital suffering from involutional depression. There was no other family history of nervous or mental disorder.

The patient was the youngest of four - the Mother died at her birth. The Father, who came of farming/

farming stock, served his apprenticeship as a Grocer, but at the time of the patient's birth, he was in comparatively affluent circumstances, and bought a farm. He was able, energetic, and successful and the patient's home circumstances in childhood were financially and socially comfortable. She had the usual childhood ailments, but no nervous traits are reported except a stammer, which became more pronounced and increasingly embarrassing in adolescence.

Between the age of seven and seventeen years she was at a boarding school. When she was eight her father re-married. The marriage was not a happy one, and the patient did not particularly care for her step-mother, but denied any gross animosity, saying that her long absences at school rendered her home contacts relatively unimportant. Her school performance in later years was not so satisfactory as at the beginning and this she attributes to the handicapping stammer. She was happy at school, had many friends, and adapted herself comparatively well. She sat the Senior Oxford Examination, but failed in Latin and French.

During her adolescence she became aware of the increasingly irritability of her Father. He was admitted to a Mental Hospital when she was eighteen years and six weeks later committed suicide by hanging. It was stated that he had business and financial worries, that his home situation was unsatisfactory, and he was extremely/

extremely agitated and depressed. He talked of an episode of bestiality, which occurred shortly after his first wife's death, and in relation to which he expressed feelings of self-loathing. Although naturally upset by her Father's death, the patient did not think that it rendered her abnormally depressed.

At this time she was living in lodgings, and attending a Commercial College. She had wished to study Medicine but her Father had not been enthusiastic, and the idea had been given up. She was uncertain and unhappy about the choice of a career. She felt that a commercial life would be difficult on account of her stammer. Accordingly, she gave up her studies and became a Hairdresser. She was described as a sensitive person, who was rather proud in many ways, and who preferred to keep her worries to herself. It was further said of her that she was self-opinionated, and that once she took up an idea she adhered to it with great tenacity and argument or opposition served only to increase her belief in her own point of view.

At this stage she became friendly with a motor-driver and a few months later found herself pregnant. She was not in love, but felt marriage was the only solution. The event was a great blow to her pride. Her Brothers and Sister looked askance at her marrying "a common working man". She dropped her former school friends and never again communicated with them. She would/

would not admit to feelings of guilt in regard to this lapse, but rather blamed her relatives for her inadequate sex education and her unprotectedness and loneliness.

Her husband was unfaithful to her while she was in hospital having this baby. She was very hurt, but confided in no one, and tried to conceal her distress. About this time she had what she calls "her first psychic experience"--"an unseen presence" seemed to encircle her and her baby, and then vanish. A night or two later she was awakened by the sensation of something brushing her cheek "like the tip of a wing". Such episodes were, however, transient.

Her second child was born in 1932 and there was further infidelity on the part of her husband. She therefore left him and lived with a Sister but, after a year, they disagreed and she returned to her husband. Marital disharmony continued. She tolerated the situation for four years, and then the husband agreed to provide her with grounds for divorce. The next three or four years were very difficult ones, and she worked hard in a variety of jobs in order to maintain her children. She was very sensitive; she complained of having few opportunities to talk to well-informed people; she was hurt and bitter in her outlook, and was said never to have been able to laugh at herself. Her Sister often told her that life would be easier if she could stand aside and see herself with a sense of humour. She felt acutely the difference in social standing when she compared/

compared herself with her Brother and Sister. She thought they could have been kinder to her. She was introspective - a keen reader, and particularly interested in medical and scientific books. The relatives were inclined to emphasize the disparity between the patient's present circumstances and her more affluent state in childhood and adolescence.

Her Divorce proceedings were completed in 1938 and in 1940 she married again. Her third child was born eight months later. Her second husband was steady and provided her with security, but was unimaginative and did not share her intellectual interests. In 1943 a fourth child was born.

From this time she dates the onset of her present illness. After the confinement she had a trance-like feeling and was in rather impaired physical health. She said there was a peculiar influence at work in the house, and thought her husband was influencing her by auto-suggestion. During the following five months she continued to believe that he could control her "sub-conscious mind". One year later she gave birth to a fifth child. In spite of these repeated pregnancies, it is said that her physical health after this last one, was good and for a time her feelings of suspicion in regard to the supernatural activities of her husband abated. Six months later, discovering that she was again pregnant, she determined to induce abortion.

After/



After a first unsuccessful attempt, she eventually carried this out. Her physical health remained good, but she suffered from intense feelings of doubt and remorse.

She was admitted to West House as a voluntary patient in May of 1946. She expressed delusions of persecution and grandeur of a fantastic nature and similar hallucinations were prominent. She first heard voices eighteen months previously and, at first, she said she regarded them as a pleasant relaxation from her own continual self-accusation. The voice was first that of "a pleasant, fatherly person" and later of a doctor. They discussed at length medical subjects such as the cure of cancer and the cure of blindness by Radar. They decided that cancer was caused by "repressions and the unconscious mind". The hallucinations, she said, "began as a good influence and only gradually became an evil one". They spoke of the end of the world not being far distant and it was suggested that her second son might mediate in this tremendous event. She thought something evil was about to befall her son and it became a duel between herself and the voices, who seemed determined to prostitute him for their own ends. To appease the voices she indulged in intricate taboos and prohibitions. This led to obsessional rituals involving the doing of things in certain order. The voices became more and more numerous, and she got so many commands that she had difficulty/

difficulty in following them all. They told her that she might become normal, but that she would never get her brain back. She expressed also depressive thoughts to the effect that she might in some way be responsible for evil which would befall her family and friends. She believed that she was "psychic" and could foretell the future, and when she told of the possibility of her son mediating between God and the World, there was a certain exaltation in her mood.

She maintained that she was sane, and insisted on leaving hospital, but later reconsidered this and decided to stay.

On the whole she was co-operative and there were no anomalies of behaviour, apart from her obsessive rituals, determined by her hallucinations. There was no formal disorder in her stream of talk, and her mood was for the most part in accord with her thoughts, although at times her emotional response impressed one as being rather inadequate. She was careful of her personal appearance , and there were no regressive features. She was correctly orientated, and her memory and general intelligence were maintained at a satisfactory level. It was easy to make contact with her and after an illness of this intensity and duration, there was little to indicate much in the way of mental or personality deterioration.

DISCUSSION

This patient's illness is of three years' duration and commenced when she was 33 years of age. Fantastic delusions are expressed which are variable and poorly systematised - that she is influenced by auto-suggestion; that she converses with both pleasant and accusatory voices; that her son may mediate between God and the World; that she may bring harm to others. Persecutory, grandiose, and depressive trends are intermingled. A certain elation is in keeping with her expansive ideas and, yet, her affect is not always appropriate, and a degree of incongruity impresses one from time to time. There has been a periodicity in the expression of overt manifestations and in the intervals social adaptation has been easier. After an illness of this duration and intensity, the general personality is well-retained. She is careful of her personal appearance and orderly in her habits. She talks freely without disconnection. The marked dullness, apathy and indifference and the anomalies of behaviour and habit associated with a schizophrenic process are here absent. There is little to suggest a progressive mental deterioration.

There is a family history of senile deterioration and of involutional depression. The even tenor of the family life was disrupted by the death of the mother at the patient's birth. She early developed a stammer which influenced the course of her later life. There/

There was a stepmother whom she did not care for. She grew into an intelligent, proud, sensitive and self-opinionated woman - not amenable to reason or advice. Her marriage was of necessity and hurt her pride. To this she reacted by blaming, not herself, but others for her inadequate sex education. Her first marriage failed. The second was to one intellectually her inferior. There were five pregnancies in quick succession, and a sixth ended in self-induced abortion. This act was accompanied by great guilt and remorse - there gradually emerged psychotic symptoms.

The links in the chain of causative factors may be an inherited predisposition; a paranoid make-up, which was sensitive, self-opinionated, over-tenacious, and proud; unable to confide, and preferring to disown shortcomings and, instead, to blame the environment; strong feelings of inferiority, developing in relation to the stammer and the first pregnancy with its estrangement from family ties and social position; intense guilt feelings, associated with masturbation and self-induced abortion.

Throughout her life she may have behaved rather foolishly and involved herself in avoidable situations, yet it is important that to these she reacted adequately and, until the age of 33, met and handled her difficulties at a good level. Her career was one of frustration which culminated in a state of intense mental unrest/

mental unrest. In relation to such sensitive developments it has been said that those so constituted are unable to express themselves adequately, with the result that emotion is dammed up in the form of conscious complexes. Thus, a painful experience cannot be forgotten, yet fails to vent itself in expression. Their pride and perseverance do not permit of such people resigning pessimistically but urge them on in spite of inferiority feelings to battle with tormenting experience. This continues until the breaking point is reached when, by the mechanism of projection, delusions and hallucinations become manifest. (Kretschmer 1934)

Here again, it seems that the integration of the personality was sufficient to withstand for many years a frustrated life situation and, when final breakdown occurred this took the form of a compromise response between a healthy aggressive approach and a complete personality collapse. In the course of further development, false rationalisations led to expansive ideas of communication with angels and of mediation between God and man.

In such a case, beginning with paranoid symptoms and showing it its course little to suggest progressive mental deterioration as is usually associated with a schizophrenic process, the study of the personality and the life situation alone seem to supply the understanding and to constitute a basis for case differentiation and classification.

CASE NO. IIIS U M M A R Y

This was a capable man of wide and varied knowledge for his station in life and possessed of a satisfactory school and work record. An external cheerfulness hid a nervous and sensitive personality. He was extremely ambitious. During the eight years he has been in touch with this Hospital he has shown ideas of reference, persecution, influence and guilt, with auditory hallucinations of persecution. These have been bizarre and poorly systematised. His illness has shown a periodicity and, on four occasions, it has been necessary for him to enter Hospital. Between his admissions he has adapted himself at a fairly good level outside, although his irrational ideas have persisted. He has very limited insight, but his personality is well retained and there is little to indicate mental deterioration.

C A S E H I S T O R Y

D. L. - aet 27; A family history of nervous or mental illness was denied. His infancy was uneventful. He started to stammer at the age of two years. This was said to follow a burning accident. He attended school from five to fifteen years. As a scholar he was above average in all subjects except Mathematics. He played freely with other boys and tended to lead and to organise their games. He was a member of the Boys Brigade/

Brigade, and a keen swimmer. Nevertheless, he was always sensitive, tense and highly strung.

Eager to earn for himself, he left school at fourteen years and obtained employment in a Biscuit Factory. At the same time he attended night school and took classes in drawing, arithmetic, and practical engineering. When aged seventeen years he became interested in literature and in psychology. He studied Esperanto. About the same time he joined a Temperance Lodge. His literary interests brought him into friendship with a young school mistress, but he quickly broke this off when he found she was becoming attached to him. For the most part, he went around with six other boys, about his own age and, although they met girls occasionally, he had little interest in them. He was a keen cyclist and went in for wrestling. He was very attached to his Mother, who was inclined to be a faddist about diet and physical culture, and he rather shared her views. His Mother he describes as one who always wanted to alter things and who hated routine. He preferred to look on her as a companion and as an equal rather than as a Mother.

At twenty years he was described as shy, sensitive and serious-minded, yet very ambitious and eager to better himself. To boss and dominate others appealed to him. With his Father he got on fairly well, but to him he was not so attached as to his Mother/

Mother. The patient always felt that his Father expected far more of him than he was able to give.

He continued for thirteen years in this rather indifferent job, giving faithful service and was described as a capable worker. He was rather moody and often felt unsettled and fed up, yet outwardly he was cheerful, although admitting that a lot of his boisterousness was to hide an inner feeling of tension.

Gradually, however, he became rather ill at ease, nervous and suspicious, and expressed the idea that people were behaving strangely towards him. These symptoms showed themselves for the first time at the age of twenty-seven years, and he was admitted for a few weeks to Jordanburn Nerve Hospital. There his difficulties were discussed with him and efforts made to give him an understanding of his personality and symptoms.

He was discharged and returned to his former employment, but remained unhappy. He was sensitive about having been in a Nerve Hospital. He felt that his fellow-workmen were passing remarks about him; he became more and more suspicious-minded, saying that he didn't understand what they were driving at.

For these reasons he changed his employment, hoping that this would bring improvement. No improvement resulted and he felt irritable and overworked. He continued however and in 1935 he got married. After some/

some months he again changed his employment. He worked in a Bakery and for some time seemed happy enough. His wife denied sexual discord, and described him as being rather shy and nervous, yet at the same time capable at his work and ambitious. He was particularly sensitive about his stammer and was determined that it would not be a social barrier.

Again, however, he resigned his post, feeling that people were watching him and looking at him in a strange way, and this time he became a motordriver-handyman. His unreasonable thoughts, however, persisted. He said he was warned by a friend in a vague way not to sign things and to watch his step. He felt there was something wrong and no one would tell him about it. He was puzzled - people seemed to avoid him. He complained of being 'run down' and told his wife things were fishy, saying: "Everything is a riddle and everybody knows the answer except me". Pains in his head became a prominent complaint.

In 1938 he was admitted to West House as a voluntary patient. He was miserable, depressed, unsettled and slept poorly. He said he ought to be working and helping others, apologising to the nurses for being in the way. He was not retarded and his answers were relevant. There were various disorders of thought such as ideas of reference, influence, persecution and guilt. At his work, he said, customers eyed him up and/

and down. When he applied for a job a peculiar investigation and cross-examination was carried out. People seemed to be watching him from the rear, but when he turned round quickly no one was there. The proprietor of the Garage where he worked seemed to him to be a suspicious character. He told of an episode when an electric clock fused and stopped - by veiled references and insinuations he was blamed for stopping it. He discerned references to himself in what people said and wrote. One day the words "suspect - let's follow him" appeared on a cartoon. He applied these to himself and wondered what it was all about. On another occasion he said: "They know I have been misbehaving and I feel as if I am in a trap".

The answer to his puzzle, he once said, was that he had been accused of homosexuality. On another occasion he said the Hospital was a Prison and that he was being detained at His Majesty's instructions. He thought there had been a trial and that he was a condemned man. Accordingly, he wrote to the King seeking his pardon.

Throughout he was clear, his memory was well-retained, he was correctly orientated, and his general intelligence was above average. His habits were satisfactory and he was orderly in his dress; on the whole, he was co-operative.

Physically/

Physically, he was slightly underweight and had been sleeping and eating poorly. There was no other physical disorder.

Insulin Therapy was given and there was a gradual improvement thereafter. He discussed his delusions and seemed to have some insight. He volunteered the information that perhaps he had a "persecution complex". He said he had had ideas that his wife was his half-sister and that his daughter was adopted. He further thought that someone had a camera and filmed him at night.

Although his insight was only partial and he continued to misinterpret, yet there was a very considerable improvement, and he was discharged after four months.

For the next five years he remained comparatively well-adjusted, although he was frequently tense, anxious and irritable. He worked as a travelling motor-engineer. In 1944, however, he had additional work owing to Staff difficulties and his brooding, irritability and suspicious-mindedness became prominent again. He went off his sleep, seemed depressed, and became tense and tremulous. He formed the impression that there were men in the attic of his house who were persecuting him and interfering with him. He made several determined attempts to run upstairs and "clear them out".

He/

He said voices spoke to him from the attic threatening him with danger if he left the house.

About this time he had his teeth extracted, and this seemed to aggravate matters. He told his wife he was followed in the street by men who were after him because of something his Father did to them. His personal papers he felt must be destroyed forthwith. He spoke of a microphone installed in his attic, and alleged there was a man there with an empty gun. His talk was strange and rather diffuse; thus, he told of a meeting with a man who gave him a ring and told him to go to his Mother's house to get a casket. He imagined he took the casket, again under instructions, to a woman whose son told him that he (the patient) was under the influence of the man who gave him the ring. He told his Mother that his Wife was his half-sister.

On admission in October, 1944, he was thin and agitated. He made efforts to escape. He said he was being persecuted. His medicine, he thought, was poison. He struck a nurse under the impression that she was interfering with him. His delusions were variable and showed no fixity. He was intensely suspicious and often refused to answer questions. During the times when he was more accessible his memory, orientation and general intelligence showed no impairment.

Gradually/

Gradually, in the course of two months, he became more settled. At this stage he was given a course of Electric Convulsion Therapy, which seemed of some benefit, although the result was not dramatic. He ceased to express his delusional ideas and it was decided to allow him to return to work.

Again, in 1945, he was admitted complaining of vague ill-health and an inability to adapt to his work and home. Ideas of reference and persecution again dominated the clinical picture.

After eight months he re-adjusted himself sufficiently well to return to work. Nevertheless, not even approximate health was attained, and he continued to harbour his delusional ideas, although he seldom gave expression to them.

DISCUSSION

For eight years this patient, whose illness commenced when he was 27 years of age, has shown paranoid symptoms. He is irritable and difficult to co-operate with; he is suspicious-minded; he is highly-strung, tense, and drives himself; a tendency to moodiness and brooding are features; when things go wrong he attributes his difficulties to his environment, rather than to himself. Sometimes he blames his employers and the stresses he has to bear - talking in terms of overwork; at other times he finds fault with his fellow-men, feeling that they are passing aspersions on him, behaving in a strange manner towards him, watching him and talking of him. Periodically, his delusions become more bizarre and poorly systematised; their colour is predominantly persecutory, but depressive and homosexual ideas are intermingled. On four occasions in eight years his thoughts have become so disordered that it has been necessary for him to enter a mental hospital. Paranoid delusions introduced the clinical picture, and have at all times dominated it. These have been accompanied by hallucinations. At times, his talk has been diffuse, and one has gained the impression of emotional facility and some disharmony between mood and thought. Persecutory delusions have determined impulsive behaviour. Emotional blunting approaching apathy, gross disconnection of thought, mannerisms, stereotypes, catatonic episodes, and deterioration of habits/

habits have been strikingly absent in the course of the illness. During the periods between mental hospital treatment, not even approximate mental health has been attained, yet social adaptation has been possible. The intellectual level is satisfactory and the personality comparatively well-retained after eight years.

A review of the personality development and experiences of this patient show that there is here no family history of mental illness. The mother, however, is described as a diet and physical culture faddist. He stammered from the age of three and this produced feelings of inferiority; he determined, however, that this should not be a social barrier. His father was proud and ambitious and always expected more of him than he was able to give. He was shy, sensitive, tense, conscientious and ambitious. He was suspicious-minded, and tended to read more into situations than was justified by the facts. Gradually, his paranoid nature became more overt; his affect was labile, and he had periods of depression. His delusions determined the falling-off in his work record; there was a periodicity in the expression of these.

Psychopathologically, one might speculate that there is here a constitution diathetically predisposed with a preponderance of potentialities for sensitiveness, suspiciousness, and latent homosexuality. Side by side with an over-developed ambition, which nurtured aims disproportionate to the capabilities, such an admixture is favourable for the development of/

of conflicts, tension, feelings of inferiority, and frustration. Upon such a background the stresses of the specific life situation are brought to bear; - the stammer, the exaggerated parental ambition, the adjustment to work, to fellow-men, and to marriage. Such an individual seems unable to tackle his problems in a healthy, matter-of-fact fashion but, nevertheless, the personality is such as to disallow a withdrawal in apathy. Rather does he mobilise thought processes, and elaborate a symbolic picture of the world which makes his internal equilibrium satisfactory. (Macfie Campbell - 1935)

Here again, although at times the thought, behaviour and mood have a schizophrenic quality, yet the maintenance of the personality after an illness of this duration and the examination of the case in "longitudinal section" suggest a process rather different from a schizophrenic development. The affective component is here clear.

CASE NO. IVS U M M A R Y

This patient was stubborn, sensitive, and of a worrying nature . He was antisocial in his outlook, and found it difficult to fit himself into society. At the age of 36 he developed delusions of a persecutory kind, together with depressive symptoms, which resulted in a determined suicidal attempt. The delusions, which were at first systematised, became in time less orderly and more bizarre. Hallucinations were present. After five years the delusional thoughts continued and determined episodically impulsive and assaultive behaviour. Throughout the affect was well preserved and, for the most part, appropriate. The personality showed little evidence of deterioration. He succumbed in 1944, thirty-six hours after leucotomy.

CASE HISTORY

J.T.R. - aet 36:- The Mother was a chronic alcoholic, and suffered from diabetes mellitus. No other history of nervous or mental illness in the family was given. The Father was an enginedriver who died at the age of 50. The patient was the youngest of a family of four. He was born in South Africa, and no abnormal traits were reported in infancy and childhood. It was, however, stressed that the family situation was unsatisfactory on account of the Mother's alcoholism. He was an average scholar and attended school from 5 to 14 years. On leaving he became employed in a Wine Merchant's office, where/

where he stayed for a year. He left, alleging that his Mother's drinking bouts were bringing disgrace upon him. He next became an apprentice engineer, but he was sensitive and rather aggressive, and found it difficult to adapt himself, so that there were frequent "misunderstandings with other men".

It was not possible to confirm confirmation of the events which immediately followed, but it seems that the patient's sister, having inherited some money, thought it an opportune moment to rid themselves of the alcoholic parent. They therefore suggested that she should go to friends in Britain and it was arranged that the patient should accompany her and there complete his apprenticeship. The sisters promised that they would thereafter pay his passage back to South Africa. The patient and his mother duly arrived in Glasgow, where the former served his apprenticeship. Difficulties, however, arose in regard to the return passage, and the patient concluded his family did not want him.

In 1921 he married, and entered an oil business; this failed in 1923. He was idle for a time, and then came to Edinburgh, where he obtained work but stayed only for a few months. He got another job with a Firm of Engineers but, after some months, developed "severe colitis", and was in hospital for three months. On his return, he found the work too heavy, and resigned. For the next few years he moved from job to job, staying but/

but a short time in each, although being fairly regularly employed.

From 1931 till 1937, however, he was only sporadically employed . Two years after the marriage a daughter was born. There were no other children. The marriage was not a happy one; the patient was moody, tended to brood, and to be discontented, showed jealous traits and was given to outbursts of bad temper, so that there were frequent rows and disagreements.

In 1937 he was asked to take a six months' training course in engineering with a view to obtaining a post. He was agreeable, and proceeded to a training centre in London. There, his sensitive, suspicious and querulent nature became more overt. He began to notice that he was not getting the same opportunities as others. He felt he was being passed over, and was not given the work to which he was entitled. After six months, he decided he had no chance of passing the test. On several occasions he tried in vain to interview the Manager. He therefore gave up and returned home, and signed on at the Labour Exchange.

He took offence at the suggestion that he should try labouring work. Considering he was being badly treated, he addressed letters of complaint to high officials. The matter was taken up with the Ministry of Labour and it was ruled that the patient had not been victimised, that he had progressed well in London, and that there had been every prospect of his being suitably placed/

placed, had he finished his course.

After further letters, interviews and demonstrations of unreasonableness, he took work as an Iron Founder. There, he thought his mates were boycotting him, because they considered him a trainee and not an engineer. He showed his "engineering lines", however, and felt for some time thereafter that he was treated extremely well and no one could do enough for him. Later, the victimisation recommenced and spread to the labourers so that he was forced to leave. He contacted the Ministry of Labour and various other bodies, but decided that it was useless, and booked his passage for South Africa. There, he was worse off than ever. His relatives, he felt, shunned him. Six months later he returned to Britain.

He obtained labouring work, but stayed only four weeks. He formed the impression that the Labour Exchange was determined to persecute him. For ten days he sat and brooded; he was worried and irritable; he told his wife he was a burden to her. He contemplated suicide and was referred to a psychiatric out-patient department. About this time he became extremely agitated, worried and depressed, and severely injured his wrist with a razor. In retrospect he said he had allowed things to dwell on his mind. His future he felt was hopeless.

This occurred in 1939, and he was admitted to West House on Certificates. He said three officials at the/

the Labour Exchange were persecuting him, and had him in their power. He was impulsive and threatened the Staff. There were frequent outbursts of violent temper in which he used obscene language. He insisted that the doctors had injected something into his penis to give him venereal disease. He was irritable and resented questions. He thought the Staff were involved in a scheme against him. He was at times intensely depressed and agitated ; he slept very badly, and was considered to be actively suicidal. He believed that a stretcher which was brought into the Ward had some ominous significance for him. He answered questions relevantly, but was non-committal and on his guard. He turned against his wife, saying she had put him in a mental hospital. His emotional reaction was predominantly suspicious and depressive. Memory, orientation and general intelligence were satisfactory.

Physical examination, including the blood Wassermann reaction was negative. He was a well-nourished man of good physique.

After three months he was more settled, and expressed few delusional ideas. He was accordingly discharged with a view to continuing out-patient treatment. His improvement was, however, shortlived. He very soon again showed evidence of severe mental involvement. He was a difficult man at home, and many times assaulted his wife so that she had to get Police protection.

In/

In 1941 he was again admitted to West House on certificates.

His delusions were now more luxuriant, loosely connected, and poorly systematised. He appeared to be listening to voices, and his outbursts and associated talk seemed obviously determined by hallucinations. These, however, he denied. He stated that nine months previously "they" opened his skull and made a diagram of his brain; that "they" had installed electric machines in his house, and were experimenting on his brain. He did not know who "they" were, but considered his wife to be involved. He spoke of a plot to electrocute him. He threatened to kill his wife, saying that she was destroying innocent women. He thought people were trying to make him crazy.

He was often quiet and polite, impressing one as a person who would cause no trouble. When, however, his delusions were discussed, he became heated and his talk was for a time rather diffuse, but this was not a prominent feature. His affect was for the most part adequate and harmonious. He said that his wife - possibly his daughter - and some other persons, had "motored his house in a bloody kind of way". One day he made this astonishing statement: "They are up to the same old trick - it's the monkey penis again - they are trying to give me a monkey penis. I can feel the current from the motor on my privates". At other times, he said he had/

had always been a misfit in the world, and must be considered a failure in life.

He worked well for a time in the Occupational Therapy Department, but he oftentimes complained bitterly of his detention, saying he was a sane man. He would shout at the pitch of his voice that the motor was on him again, and that his wife was trying to destroy his penis. On other occasions, he would declare that "they" were after his poor wife and that his daughter was suffering too.

He escaped once, broke into his house, and sat awaiting his wife's return. He was immediately sent for, and came quietly back to hospital, apparently treating the matter as a joke, and saying that forbidden fruit was always best. On yet another occasion, he said that the University trained young boys and girls to drive people mad, so that "abnormal pansies" like the doctor could experiment on people's brains. There were frequent episodes of assaultive behaviour, when he was unapproachable.

Nevertheless, after an illness of at least six years' duration, and probably much longer, his personality was well retained. He was always tidy in his appearance, he could most times converse in a perfectly coherent and normal way. Affective blunting and incongruity between mood, thought and behaviour were not prominent. Mannerisms, stereotypies and other usual manifestations of/

of schizophrenic deterioration were not seen.

He died in 1944 thirty-six hours after leucotomy, as a result of intracerebral and brain-stem haemorrhages.

DISCUSSION

This patient died in 1944 following prefrontal leucotomy. His illness, which was of nine years' duration, had presented with paranoid symptoms with initially a strong depressive component. As development proceeded, multiple fantastic and poorly-systematised delusions came to be expressed, and to be accompanied by hallucinations. There was at times a diffuseness of talk and occasionally the affective response impressed one as less than appropriate. Generally, however, the emotional response was in harmony with the behaviour and thought, and nothing approaching apathy and indifference was ever seen. Mannerisms, stereotypies, and other behaviour anomalies were absent, except for outbursts of assaultive behaviour determined by persecutory delusions and hallucinations. After nine years the personality was well-retained and mental deterioration was not a noticeable feature.

The mother was unstable and a chronic alcoholic. The patient was the youngest of four. Parental disharmony and alcoholism resulted in an unhappy early home situation. In the course of the personality development the following traits became clear - sensitiveness and feelings of inferiority, aggressiveness, and an inability to adapt socially. This resulted in frequent "misunderstandings with others". To these were later added more conspicuous paranoid trends; thus, his suspicions led to the development of over-determined and illogical notions - that he was not wanted; that

he/

he was the "odd man out"; that he was denied the opportunities given to others; that he was being passed over and ignored. He became querulent and demanded redress . When it was proved that he was acting unreasonably, he remained unconvinced . Delusions of persecution followed, and later the transient appearance of depression with suicidal attempt. Gradually, there evolved poorly-systematised bizarre delusions, with hallucinations, and aggressive and anti-social behaviour.

Here can be clearly seen the state of affairs which Meyer (1913) described as a transformation of the personality in which reason is preserved but side-tracked; where the individual is continually ready to see a biased meaning in things , and where to the indifferent actions of others are attributed deliberate intentions, where suspicion and an anti-social attitude prevail.

Constitutional predisposition may be here present as a legacy from the unstable, alcoholic mother. The early unsatisfactory environment may have sown seeds of difficulties to come. The jealousy and suspicion; the marital disharmony, and the tactile genital hallucinations substantiating delusions of assault may permit speculations of a latent homosexual trend. Feelings of inferiority and insecurity may derive from the constitution, or from it and the early family situation . Against such a background the needs of social adaptation were met by a further and more grave development of those/

those very traits which characterised the personality. Thus, the paranoid pattern of reaction progressed to delusional formation and a perverted picture of reality was painted to compensate for personality deficiency. The strong affective undercurrent in such paranoid states has many times been stressed . White (1936) considers the intellectual aspects to be explanatory of the feelings - rationalisations of the position the patient finds himself in as interpreted by his feelings. Here the disorder of mood is again clear. The feelings of unworthiness; of being a burden to others; the agitation, and the determined suicidal attempt constituted a real, though short-lived, episode. May it be that temporarily the mechanism of projection and the ability to falsely rationalise the feelings were in abeyance, and allowed a glimpse into the turmoil of guilt and inferiority to be quickly closed from view by the further operation of these mechanisms which restore the internal equilibrium at the price of paranoid delusional development.

TABULATED EXTRACTS OF INFORMATION FROM ALL TWELVE CASEST A B L E IFAMILY HISTORY OF NERVOUS OR MENTAL ILLNESS

Depression	4)	
)	
Neurosis	1)	
)	7
Chronic Alcoholism	1)	
)	
? Schizophrenia	1)	

UNSATISFACTORY HOME SITUATION IN EARLY LIFE 11NEUROTIC TRAITS IN CHILDHOOD 6SCHOOL RECORD

Below average	2
Average	7
Above average	3

WORK RECORD

Satisfactory	8
Unsatisfactory	4

MARRIED 7

Marital disharmony	6
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T A B L E I I

SENSITIVENESS	12
SENSE OF INFERIORITY	10
RESERVE	8
SHYNESS	8
CONSCIENTIOUSNESS	8
HYPOCHONDRIASIS	8
SUSPICIOUSNESS	7
AMBITIOUSNESS	7
QUICK TEMPER	6
SENSE OF INNER TENSION	6
OBSTINACY	6
POSSIBLE LATENT HOMOSEXUALITY	6
TENDENCY TO BROOD	6
MOOD SWINGS	5
JEALOUSY	4
OBSESSIVENESS	4

This Table shows the case incidence of the outstanding prepsychotic personality traits of this group.

T A B L E I I I

<u>AVERAGE AGE IN YEARS OF ONSET</u>	30 $\frac{3}{4}$
<u>AVERAGE DURATION</u>	5 $\frac{1}{4}$
<u>NUMBER PRESENTING WITH PARANOID DELUSIONS</u>	12
<u>NATURE OF DELUSIONAL FORMATION</u>	
Systematised	1
Poorly Systematised	8
Unsystematised	3
<u>CONTENT OF DELUSIONS IN ESTABLISHED CASES</u>	
Persecutory	1
Persecutory plus depressive	6
Persecutory plus grandiose	4
Persecutory plus grandiose plus depressive	1
<u>NUMBER SHOWING HALLUCINATIONS</u>	
Early	4
Late	7
<u>NATURE OF STREAM OF TALK</u>	
No disorder	7
Diffuseness	4
Disconnection	1
<u>NATURE OF EMOTIONAL REACTION</u>	
Adequate	4
Slight blunting	5
Inadequate	3

T A B L E I I I (C O N T D .)STATE OF CONGRUITY BETWEEN MOOD, THOUGHT AND BEHAVIOUR

No incongruity	4
Slight incongruity	8
Gross incongruity	0

STATE OF MEMORY AND ORIENTATION

Satisfactory	12
Impaired	0

CASES SHOWING EVIDENCE OF MANIC-DEPRESSIVE
ADMIXTURE

6

NATURE OF INSIGHT

Full	0
Partial	3
None	9

COURSE OF ILLNESS

Periodicity with temporary social adjustment	5
No periodicity	7

EVIDENCE OF PROGRESSIVE MENTAL DETERIORATION
WITH SEVERE PERSONALITY DISINTEGRATION AND
USUAL TERMINAL SCHIZOPHRENIC SYMPTOMS

0

GENERAL DISCUSSION

Table I gives some indication of the background and the social adaptability of these cases. In seven there is a positive family history of nervous or mental illness, as would be expected, since 50% to 60% of such material shows a family record of mental breakdown. The nature of these family reactions here are predominantly depressive, with four instances of suicide. The association of paranoid and depressive states is not uncommon. Gaupp (quoted by Kraepelin) mentioned cases with what he called Depressive Paranoid Predisposition in whom, under the pressure of painful circumstances, a distrustful delusion of reference with a certain amount of insight and fluctuating course insidiously developed without leading to rigid systematisation. Schulz (1940) in his investigations on heredity believes it possible that there is a genetic factor common to both manic-depressives and schizophrenics (using schizophrenia in its widest sense) The work of Cobb and Penrose in this regard has already been mentioned.

In the early family situations there are four cases of disrupted home life and deficient parental example due to the early death or departure of either one or the other of the parents, and an equivalent situation, as a result of illegitimacy, in two further cases. In all but one the family situation in early life was described/

described as unsatisfactory, due to such factors as alcoholism, parental disharmony, mental illness, suicide, broken homes, and illegitimacy. It is here of interest to note that Faris and Dunham (1939) in an investigation of the social incidence of schizophrenia found the pattern of distribution was similar to that of many social abnormalities, and that the paranoid states followed this pattern most closely. This would seem to confirm the importance of a study of the life experience for a proper understanding of these reactions.

In half the cases there was little to suggest nervous traits in childhood and adolescence. In the remainder, these were present in the form of stammering, feelings of nervous tension, and various fears.

The satisfactory school and work records in the great majority of cases seem to indicate a degree of maturity and personality integration which surpasses that usually found in the potential schizophrenic and, yet, in certain aspects of social adaptation, deviations of reaction demonstrate defects of personality structure. Thus, in the seven married cases, six give evidence of marital disharmony. The possible association of this with latent homosexuality seems likely. In six cases there was a suggestion of such trends in the pre-psychotic state, and in three of these the suggestion was strengthened by the appearance later of homosexual delusions. The importance of this factor in the genesis of paranoia is stressed by the psychoanalytic school.

In regard to the psychotic development the average/

average age of onset was over 30 years. This is rather later than is usually found in the schizophrenic reaction type, where the maximum incidence is about the 25th year. All the cases began with paranoid symptoms in the forefront, and such symptoms have continued to dominate the clinical pictures throughout their course. Half the cases showed an admixture of depressive symptoms, with four instances of suicidal attempts. Further, it should be noted that five of them showed some degree of periodicity in the manifestations of gross symptoms, which allowed of temporary social adjustment. In the course of development the delusions, which were at first to some extent systematised, became poorly systematised or un-systematised - expansive ideas appeared in five cases. In eleven the delusions became of a bizarre and fantastic nature and a similar number showed hallucinations. The emotional reaction was impaired in eight cases - in five of these this was not a prominent feature, and was apparent only from time to time as a response, rather shallow and blunted, and less than the situation seemed to demand. This was associated with a similar degree of disharmony between mood, thought and behaviour. In three the affect was frequently inadequate, but in no case was there that persistent dullness, indifference and apathy which characterises the schizophrenic state. Four showed a diffuseness in their talk from time to time, and in one this episodically amounted to disconnection/

disconnection. Gross incoherence, however, was characteristically absent. Three-quarters of the cases had no understanding of their illness, and in the remainder, insight was but partial. Yet, a terminal state with unmistakable symptoms of weak-mindedness which Kraepelin thought was usually reached in the majority of schizophrenic cases in the course of two or three years was in no instance found in this material and, after an average duration of five years and more, the personalities were retained at a surprisingly good level.

Therefore, on the basis of these findings, I am of the opinion that such paranoid states are much more closely allied to the paranoid reaction type than to the schizophrenic reaction type, and that this alliance is apparent in the pre-psychotic personality, the symptoms, and the course. It is true that some schizoid features appear in the personality, and schizophrenic symptoms in the clinical picture. It is equally true, however, that schizophrenic symptoms may appear in other states - they may be found in what is essentially a toxi-exhaustive psychosis; they may be found in conditions which are primarily manic-depressive psychoses or psychopathic states, and they may constitute the prominent features of those suffering basically from some organic cerebral damage. With this in mind it seems reasonable to infer that schizophrenic symptoms may appear in what is essentially a rather different process; namely, a paranoid reaction type. This seems undoubtedly/

undoubtedly to be borne out by the clinical findings. We do not speak in terms of ^atoxi-exhaustive schizophrenia or psychopathic schizophrenia, for such clinical expressions would merely serve to complicate the issue and obscure the essential diagnosis. It seems unlikely, therefore, that we are any more justified in using the term paranoid schizophrenia for a state which is characterised and dominated by paranoid delusions and hallucinations which seems fundamentally determined by a paranoid makeup, which runs a chronic insidious course or one showing a certain periodicity, and in which the personality is well-retained after many years - even if schizophrenic symptoms may appear from time to time throughout the illness. Detachment from the external world, incongruity of feeling, incoherence of thought, and peculiarities of behaviour - the cardinal symptoms of schizophrenia - nowhere dominate the clinical picture here. It seems in the sphere of discrimination, judgment and interpretation that the characteristic impairment is to be found.

The paranoid-depressive admixture already mentioned in this series, the tendency to some periodicity in the manifestation of gross symptoms, and the depressive family history require further consideration. A very large literature has arisen in regard to physical methods of treatment in psychiatry and more than a passing reference to it is beyond the scope of this thesis. It is rather striking, however, that in the treatment of schizophrenia by electric convulsion therapy, insulin therapy/

therapy and prefrontal leucotomy, probably the majority of investigators report the best results in the paranoid states. Thus, with electric convulsion therapy (Kalinowsky and Worthing - 1943) consider paranoid schizophrenia with delusions and hallucinations to have the best outcome. In regard to the idea that insulin produces better results with paranoid schizophrenia than with any other types, Henderson and Gillespie (1946) suggest that the material may be in fact episodic paranoid states bearing a close relationship to the manic-depressive group. In the treatment of schizophrenia by prefrontal leucotomy Frank (1946) obtained his best results with the paranoid states, and goes on to comment that the implication of clinical experiences with regard to prognosis in both insulin and leucotomy treatment of schizophrenics may necessitate again the splitting of such cases into dementia praecox and paranoid groups as separate disease entities contrary to Bleuler's views.

It has already been stated that White and Henderson and Gillespie have felt disposed to separate all paranoid states from schizophrenia. This thesis would seem to strengthen such a view, and what might be termed the therapeutic tests here mentioned constitute yet further confirmation. Such physical treatments are most effective where the prepsychotic personality is better integrated and electric convulsion therapy and leucotomy have been of particular value in such affective/

affective states as involutional depressions. The case material here presented together with the reported results of physical therapy suggest that paranoid states may be more closely associated with affective disorders than has been generally realised.

The nature and the relationship of the schizophrenic and the paranoid states has received much consideration in the past . It has been suggested that such comprehensive terms as "the schizophrenic-paranoid series " or "paraphrenia" might be used in regard to them to emphasise their essential unity, in the belief that the difference is one of degree and not of kind. To so criticise their separation on this assumption seems to me irrational. In psychiatric practice it is the exception to find states in anything approaching pure form. Overlapping in greater or less degree of well-known syndromes is almost constant nor, in many cases, is it possible to clearly separate neurosis from psychosis. Thus, viewing the subject broadly, the suggestion that we are dealing with differences of degree and not of kind could with equal justification have a much wider application. Should this argument be carried to its logical conclusion we would eventually return to the concept of one, and only one, mental disorder. Such an approach seems hardly destined to clarify the issue. Further, to speak in terms of kind is to assume a knowledge of aetiology which we do not possess.

Macfie Campbell/

Macfie Campbell (1935) has said that types of reaction or mental mechanisms are not specific for any mental disorder, but are general characteristics of the human personality, more marked in some individuals than in others, and suggests that what we have to do is to group cases together, which have a certain degree of similarity, and by studying these groups separate what is individual and incidental from what is general and essential. With such an approach case differentiation seems to be on a surer basis, and I feel amply justified in separating all paranoid states from schizophrenia and regrouping them with paranoia and paraphrenia under the heading of the paranoid-reaction type, without attempting too fine a differentiation between these included sub-groups.

This differentiation is based on the pre-psychotic personality type, the reactive tendencies, and the symptoms and course, which are found to have a pattern common to all. By so doing, I believe that the determination of the prognosis, and the outcome in deterioration can be facilitated, and that the probable response to the newer physical methods of treatment can be more accurately assessed.

SUMMARY AND CONCLUSIONS

SUMMARY: The problem of the classification of what are generally designated the paranoid states of schizophrenia has been discussed. In a brief historical sketch some theories regarding the nature of the schizophrenic and paranoid psychoses have been reviewed, and some of the more outstanding landmarks in the evolution of our understanding of them has been dealt with. In particular, reference has been made to the work of Kraepelin, Bleuler, and Meyer and the more recent contributions of Mapother, White, Macfie Campbell, and Henderson and Gillespie. The division of this material into the schizophrenic and paranoid reaction types following the psychobiological approach has been considered the soundest and the most practical basis for the differentiation of cases and for a clearer understanding of their nature. By comparing and contrasting these reaction types, from the point of view of personality, reactive tendencies, psychopathology, symptoms and course, important differences are brought out in the light of which the case material is examined and reassessed. The problem resolved itself into deciding to which of these reaction types the paranoid states most closely approximate. The relation of these states to the affective psychoses has been examined, and their response to physical methods of treatment, as shown by current literature, considered

CONCLUSIONS: /

CONCLUSIONS: (1) Paranoid states are more closely allied to the paranoid reaction type than to the schizophrenic reaction type for the following reasons:-

- (a) The pre-psychotic personality is rather different from the schizoid type and approximates more closely to the paranoid makeup, with frequent appearance of latent homosexual trends.
- (b) The social adaptability, as indicated by the school and work record and general adjustment, indicates a degree of maturity and personality integration seldom found in pre-schizophrenic states.
- (c) The age of onset is usually later than in the schizophrenic reaction type.
- (d) The clinical picture is introduced by paranoid delusions which continue dominant throughout its course in contrast to the schizophrenic reaction type, where delusions are secondarily determined by affective delapidation.
- (e) There is little to indicate personality disintegration and mental deterioration after illnesses of several years, of the kind that is seen in the schizophrenic reaction type after illnesses of two or three years and often very much earlier.
- (f) A common constellation of reactive tendencies whose pattern is predominantly paranoid can be traced throughout the life histories and psychotic developments.

CONCLUSIONS: (2) Confirmation of the contention that paranoid states involve a different process from schizophrenia is obtained by a reference to the literature in regard to the newer physical methods of treatment in such conditions . There it is found that with insulin, electric convulsions, and prefrontal leucotomy the best results are claimed in the paranoid states.

(3) The association of paranoid and affective disorders is here demonstrated, and it is tentatively suggested that this association may be stronger than has been generally realised. This relationship may in part determine the more favourable response to physical therapy so frequently found in paranoid states.

I wish to thank Professor D.K. Henderson for permitting me to use the clinical material and case records at the Royal Edinburgh Hospital for Nervous and Mental Disorders for the purpose of this investigation.

A P P E N D I X

PRESENTATION OF REMAINING EIGHT CASE RECORDS

CASE No. VS U M M A R Y

An impulsive, quick-tempered and rather aggressive man who gradually became mentally involved whilst serving in the Pioneer Corps. Numerous unsystematised, bizarre and fantastic delusions came to be expressed of reference, persecution, and grandeur together with visual and auditory hallucinations. Episodic impulsive behaviour followed and there was at times a diffuseness in the talk amounting occasionally to incoherence. The mood was variable, but for the most part in harmony with the thoughts expressed. There was at all times a lively affective response. Insight into the seriousness of the illness was always completely lacking.

C A S E H I S T O R Y

J.T. - aet 36: The patient was admitted in October, 1943. There was no history of nervous or mental trouble in the family. He was a normal child and attended school from 5 to 14 years. He often played truant and was at all times stubborn and obtuse. While his father served in the Great War his mother had considerable difficulty in disciplining him. He commenced work as a message boy at 14 years and later worked as a coalman. He had considerable periods of unemployment and found it difficult to fit into his social milieu. He got on well with people and was the opposite of shy, but he was sensitive and impulsive and easily precipitated into fits of bad temper/

temper from which, however, he quickly recovered and repented the next minute. He was never involved with the Police. He was a moderate drinker and a heavy smoker. In 1930 he married an Italian woman and there were three children of this union. The home life was happy although the husband's sensitive and aggressive traits led to disharmony at times. In 1940 his wife died of T.B. The children were placed in a Convent and the patient joined the Army. He was posted to the Pioneer Corps and performed his duties efficiently enough but was in hospital on several occasions with gastric upset, gonorrhoea, and bronchitis.

At the end of 1942 he began to express strange ideas of a persecutory nature while he was in hospital with a gonococcal epididymitis. He formed the opinion that the doctor gave him medicine which caused his stomach to tighten up as if it were going to burst. Later, he felt that the doctors were trying to make a human guinea pig out of him and that they were trying every trick to trap him. Imaginary voices kept saying to him "Watch yourself" .

He was transferred to a Military Mental Hospital early in 1943 and his sister, who visited him, saw a great change. He was nervous and restless; he told her that the doctors were putting dope in his food to injure him; he said he had seen a vision of God.

One month later he was discharged from the Army and/

and sent home . There he continued to act strangely - he was never still; he was always leaving the house and returning after a few minutes. He said that his sister was the recipient of dope from the Army and that she was putting it into his food. He thought that people on the streets were talking about him and looking strangely at him. He thought the Army had powers to "work on him" and to cause his stomach to "tighten up".

On admission to this Hospital he was at first co-operative and his talk was coherent and relevant. There was a certain amount of suspicion, but it was not difficult to make contact with him and he described his difficulties in some detail. He said that in 1940 he had experienced tremors in his stomach like electricity. In 1942, as a result of a powder given him by an Army doctor, his stomach tightened up; that night he was ill, but the next morning he found he had great strength and "could bend huge pieces of metal with ease...his arms swollen a terrific strength". Later, he suffered from bronchitis and the medicine given him "almost burst his chest". He went on to say: "I have all my inner feelings - I can feel sad and happy - but I haven't got my outer feelings. Although I can feel touch and movement my brain doesn't register that I have the top parts of my legs and arms... I was getting all my feelings back, but they are away again. I want my feelings back - without them life isn't worth living...It is life or death.../

"death... I feel I am going about like a mechanical man. I see visions...one was like a cloud drifting towards me - it wasn't a complete vision, but it was trying to form into a vision...I saw visions of crowds of men all marching - they looked like disciples - disciples of Christ even now I seem to have some controlling influence inside me. I've got a life ahead - I've got to be of some use in the world. I'm going to have something I never had before". He went on to say that he felt something unearthly about him; that he had a mission to perform.

He was convinced that the Army had taken his feelings from him and refused to let him have them back. At the Military Mental Hospital a voice kept telling him to trust in God Almighty. He was given medicine there which "froze his nerves." When he looked in the mirror he saw he was "just a walking corpse". He felt the Army was having a kick out of him, and because his sister was "keen to get him certified" he felt she must have something to do with it too. He was rather vague and diffuse in his conversation but was able to give an account of his previous history, although this was rather coloured by his delusions.

He was correctly orientated. His memory and grasp of general information were satisfactory. His intellectual level was average.

A year after admission his general behaviour had become more difficult and management was more of a problem/

problem. Episodically, he was impulsive and assaultive. His delusions became more numerous, with little evidence of systematization. Side by side with the persecutory ideas there appeared expansive delusions of a most grandiose nature. He was intensely suspicious, considering the medical staff to be poisoning him through his food and medicines. He accused the doctor of keeping the dead bodies of his victims beneath the floor of the Ward. He thought he was a great General leading Armies in various parts of the globe. He said he owned many Foreign countries and islands. He was an Indian Prince one day, and the next King of Scotland demanding to be removed forthwith to Holyrood House. He denounced his sister, saying she was not of Royal blood.

His mood fluctuated between an elated phase, in which he talked vociferously of great achievements, and a phase characterised by suspicion and aggression in which he hurled foul abuse at his fellow patients.

His orientation and memory remained unimpaired. At times his talk was difficult to follow. His affect was lively and, for the most part, consistent with his thoughts. Affective blunting and facility of attitude were not marked features. There was some incongruity between thought and action, for he took his food, although maintaining it was doped.

He attended to his personal cleanliness and to his natural functions and, when his attention could be held while he was untroubled by hallucinations, he could converse/

converse rationally, although rather vaguely.

His condition showed no remissions and during the second year his delusions became more bizarre. Thus, he said he carried the Royal birthmark below his left ear. He said there were human bones in his soup and dope in his tea. His language was often obscene and, although he could converse rationally, he became excited and abusive as soon as he was crossed. His habits were at all times satisfactory.

After three years his condition had shown little change, and prefrontal leucotomy was carried out. In the sphere of his behaviour the improvement was dramatic. The persecutory delusions continued, but the emotional response which they previously evoked was noticeably diminished. He became employable and pleasant in his bearing and his talk. After six months, when his discharge was under consideration, he escaped and was discharged by operation of Law after 28 days.

Since then he has taken up work as a coalman and has reported back periodically. He was most apologetic for having departed as he did, and the affective response was active and appropriate. Ideas of reference persisted and a certain diffuseness of talk was apparent, although slight, and unobserved by casual acquaintances. His personality was comparatively well-retained. It was clear, however, after examination that he remained considerably involved mentally.

A year later it was reported that he was again giving expression to his delusional ideas to such an extent that social adaptation was becoming increasingly difficult and he was unemployed. His relatives were advised that should this phase continue, re-admission to a Mental Hospital would be necessary.

CASE NO. VIS U M M A R Y

A shy, self-conscious and sensitive person who, from an early age, had been of a tense and worrying nature. Even at school he harboured ideas that others were against him. He managed to adapt himself quite reasonably to Army life here and abroad. At the age of 28 years he broke down with an illness characterised by delusions of a depressive, persecutory and grandiose nature of a rather bizarre kind, and accompanied by prominent auditory hallucinations. After an illness of over 20 months the depression has faded, and the paranoid delusions dominate the clinical picture. The affect is appropriate, the personality is well-retained, and there is little evidence of mental deterioration.

C A S E H I S T O R Y

R.T.S. - aet 28: This man was admitted to hospital in October, 1945, on Certificates. Previous to this he had been continuously under care and treatment for five months. His relatives first noticed an alteration in him in April, 1945, upon his return from two-and-a-half years' Service in India. There are indications that he was having difficulties for some months previous to this.

He enlisted in 1939, being placed in a lower medical category because of visual defect. During the whole of his Service career he was in the Accounts Department, proceeding to India in 1943 and there remaining/

remaining for two-and-a-half years. He was not invalided and had not reported nervous trouble abroad.

The family history was a bad one. The patient was the youngest of four. The eldest sibling at 19 years developed a nervous illness in which she is said to have been at first bright and talkative, and later so depressed that she unsuccessfully attempted suicide by drowning. Shortly afterwards she died as a result of a perforated appendix. The next daughter admitted to a 'nervous breakdown' in 1944, during which she received psychiatric out-patient treatment. She remained tense, talkative, fussy and rather unstable at the interview. A brother, born in 1913, was a normal healthy boy until the age of 20 years, when he developed nervous symptoms, lost confidence, and became unable for his work. He is described as not being able to enjoy things and tending to brood; he was unable to get 'anything off his chest'. He joined the R.A.F. and, after being evacuated at Dunkirk, became mentally involved and was in hospital. He was discharged from hospital in 1941 and committed suicide in September of the same year. Of two paternal cousins, one shot himself at 34 years, and the other had an illness at the menopause. There is little information about the father, who died of cardiac asthma after a period of invalidism in 1940. The mother is alive and of an extremely tense and anxious disposition; at interviews she shows considerable tremor and her excitement disallowed/

disallowed of her adequately expressing herself.

The early home situation was an unsatisfactory one. There was constant disharmony between the parents, and this put a strain on all the children.

As a child the patient was shy, serious-minded, conscientious, and of a sensitive disposition.

His record at school was satisfactory and he tried to interest himself in Sports, but his sensitive nature and his anxious-mindedness were always there, and if he thought he had given offence, he worried and brooded. He felt that others tended to make fun of him and to be antagonistic to him, and he had to fight those feelings always, so that he was always under considerable tension.

This information was given by the patient and his sister, to whom he had confided, yet it seems that he appeared normal. Others did not notice fears, idiosyncracies, or oddities of behaviour and the mother always regarded him as normal in every way. He had no illnesses of note and no previous nervous breakdown.

After leaving school he worked for a short time as a Clerk before enlisting in 1939. He apparently adapted himself well to Army life, both in this country and overseas. He says that he enjoyed it; that he was always able to do his work, and denied any depressive ideas whilst in India. An Army report stated in effect that his work record was satisfactory, that he had been employed/

employed as a Clerk throughout his Army career, that he was reasonably well-adapted overseas and that he was a man of good intelligence, although rather evasive. He had shown no signs of overt instability or other evidence of psychopathy.

Immediately on his return from India early in 1945 he complained of headaches, of an unsettled feeling, and of an inability to cope with his duties. He felt weak and unable to concentrate; he suffered from headaches, sleeplessness, and lack of appetite. He felt life was hopeless and told others he was not doing his work properly. He said he should be made to serve a prison sentence as a punishment.

He was referred to a psychiatrist and placed in hospital. He said people were laughing at him because he had got himself into this state. He thought he had let the Army down. He was obsessed with the idea that he was dirty and touched his clothing as if it were soiled. He referred to the dirt coming from inside and demanded a clean battle-dress. He made two suicidal attempts. He was hallucinated and kept hearing his name being called. He didn't know what was going on. He was bewildered and felt that something sinister was afoot. He tried to cheer up and managed to do this, but only for brief intervals.

He continued to be hallucinated and deluded, but there was no emotional blunting and he was correctly/

correctly orientated. In June, 1945, the case was diagnosed as undoubtedly one of Schizophrenia. In September, 1945, however, he was invalided as a Depression.

On admission to this hospital he was dejected and bewildered - episodically, he became agitated and emotional. He was preoccupied with ideas of unworthiness and guilt. He appeared to have difficulty in thinking. His orientation and memory were intact, and there was no clouding of consciousness.

Physically, his face was of a muddy yellow colour and he had lost some weight. He was examined by a medical specialist, who found nothing amiss. An expert haematologist reported that the result of his blood examination was entirely normal - the blood sedimentation rate was normal; the blood pressure was 150/70. He was afebrile throughout. He wore spectacles to compensate for a visual defect on account of which his Army medical category had been C 3.

He had received a course of Electric Convulsion Therapy in a Military Hospital with little effect. In view of the depressive component of his mental picture, he was given a further course. This had the effect of improving the depressive aspect, but he continued to express delusions and to be hallucinated.

At this stage his thought content is best demonstrated by the following notes made by him:

"When/

"When I returned from India I was put on work I had never done before - with the usual rush for output. The inevitable happened, and I started to make mistakes and miss things that should have been checked. I tried to carry on but soon realised it was not fair to all concerned, and my nerves and conscience played havoc with me to think that I had been making mistakes. I decided to end it all. I had always carried out my duties faithfully and made sure the soldier got everything he was due. Then I decided to face it and reported to the Officer that I hadn't been doing my duty properly.....I thought of all the handreds and hundreds of mistakes which had been made by others' 'don't care' attitude and consoled myself with the thought that after five-and-a-half years' of faithful Service, perhaps I needed a rest. I admit I have never been brilliant, but I have always been able to do what was asked of me. I realised I was lucky being in the Pay Corps, and had I been transferred to any other Unit I would have relinquished my stripes.....at this stage I thought I would come all right, and perhaps face a charge of breaking down in my duties.....be severely reprimanded and reduced to the ranks.....Then events started to move rapidly, and I began to realise something was wrong - that my mistake had been bigger than I thought, and somebody had cashed in. I was nervous and depressed - I truthfully tried to tell what I thought had happened, but I did not seem to satisfy the Authorities/

Authorities.....all the other patients seemed to be happy, and again I thought that perhaps I had created a new world and I could have a place.....This persistency of 'speak' came to me. I did not know what to say.....Incidentally, a strong desire to live decently came to me, and the thought of being 'sweet 28' and 'never tasting the joys of life' filled me. Things in this hospital were at first all right. Eventually, the patients seemed to regard me as something unusual and the talking in riddles started again. I was told by one that he had seen a Chinaman who looked like me. I presume he meant I was yellow - but after electric treatment, injections, removal of blood, tubes stuck up my rectum, I thought I had taken my medicine. I admit I am no hero but, after all that, it is natural that I am a bit scared. This talking in riddles continues, and a voice keeps telling me to speak..... Then I realised that medical science had taken such terrific steps that I was filled with apprehension. It seemed that everyone could know what I was thinking and that thoughts could be transposed to my mind. I hoped that this advance in medical science would be put to advantage and not to man's disadvantage.....it seemed as if the blame for everything was being directed at me. However, most people seemed happy, and I thought I had certainly benefited humanity.....anyway, one man could not be responsible for all that, and this animosity/

animosity filled me with fear.....I don't regard myself as a Criminal, but if I am so, perhaps I will get a chance of a fair trial.....sometimes I felt I got a reputation for being greedy, and this was because I washed, bathed, shaved and smoked. Greed has never been one of my qualities, and I have been generous and decent to people who need it.....after all I have gone through, I feel no man could have faced it without some signs of nerves.....Then by this transportation of thoughts to the mind, it appeared it was jealousy I had been suffering from.....I seem to have created a new world which has made millions happy, but I still don't quite know what it is all about. Everything here is done to keep me on the hop'.

Although the depressive aspect of his illness faded some twelve months ago following the second Electric Convulsion Course, the delusions of reference, influence and persecution, together with expansive developments and accompanied by hallucinations, have persisted and have come to dominate the clinical picture.

The illness is now of approximately 20 months' duration and there has been little change. The Paranoid ideas are uppermost, the personality is well-retained, mental deterioration is absent, and the affect is appropriate. The patient is convinced that things are going on around him which are directed against him; that he is accused and controlled, and that thoughts are put into his head. He feels that people who interfere with him /

him are against him for their own reasons, and that he has potentialities which are being held in check . He does not feel that he has brought this sort of thing upon himself, and he feels that if he could be freed from this persecution he could do worthwhile things, and help other people.

The rather unhealthy, muddy, yellow complexion noticed initially cleared in the course of the first few months, and the patient's physical condition is now very satisfactory yet this has not resulted in any amelioration of his mental state.

CASE NO. VIIS U M M A R Y

A sensitive and highly ambitious man with a good school and work record, who was always persistent and conscientious in his efforts. He broke down at the age of 34 years with a delusional illness. This was characterised by poorly systematised delusions which in time developed a bizarre character and came to be accompanied by hallucinations. The affect was for the most part consistent with the ideas expressed, although there seemed at times to be a certain incongruity. The mood tended to change quickly, and a considerable depressive colouring was present. After three to four years the patient's personality is very well retained and mental deterioration noticeably absent.

C A S E H I S T O R Y

J.B.C. - aet 34: No history of nervous or mental illness was admitted in parents or grandparents. A brother, William, who was said to be quiet, philosophic and fatalistic, often had ideas of inferiority and felt he was unwanted. He was admitted to a Nerve Hospital with a breakdown diagnosed as melancholia. A few months after discharge he shot himself.

The patient had a normal childhood. He was fourth in a family of seven. He did well at school, and was nearly always top of the class. His father died when he was 13 years old, leaving his mother a young widow to bring up the family. The patient was very sensitive and highly/

highly ambitious; he was hardworking and conscientious. He had to leave school prematurely owing to economic circumstances, but he continued to educate himself whilst working in an office. Eventually he managed to enter a Physical Training College. Thereafter he held various positions of increasing responsibility as a P.T. Instructor.

An informant, who was for a time a pupil of the patient's at school, stated that he was competent, but easily hurt and rather suspicious-minded. Thus, he would become disgruntled and easily hurt if he thought his pupils were trying to take advantage of him. He was unable to take a joke against himself well and, on the whole, he seemed to adapt himself less well to his situation at school than his predecessors and successors.

He was a married man and has two children aged $4\frac{1}{2}$ years and 2 years. His married life has been happy, but the mother-in-law has always felt that he was not quite good enough for her daughter. His hobbies were gardening, music and dramatics. He was a very moderate drinker and a non-smoker.

He was admitted to hospital as a voluntary patient in July, 1944. His wife said that his illness had been developing for some years. When the war began he undertook evacuation schemes, and later was subjected to bombing, which he found a considerable strain. He wanted to join up but was reserved. In 1943 his wife became ill and, at the same time, he failed to secure a certain/

certain job. He had a "mild breakdown" and felt he was being followed. After a holiday he was much improved. He returned to work in three months' time.

In February, 1944, a young nephew died of meningitis. From this time on he distrusted all doctors and could not sleep at nights. He felt no one wanted him and that he was not doing things properly. In June, 1944, he was suddenly seized with the idea that someone was going to do away with him. He felt someone was responsible for a small boil which he had on the back of his neck and that his life might be in danger. He thought people were turning against him. He saw a psychiatrist who is said to have recommended golf, but he became worse. He was now convinced that everyone was organised to persecute him. One day when he arrived home his father-in-law was by chance in the house; he concluded that this was a "put-up job". Later, he turned against his wife, saying that she was to blame for everything. He seemed terrified and kept speaking vaguely about "them". It was impossible to reason with him. He lost some weight and became easily tired. He next thought his wife was going to leave him, but eventually decided that this was not so.

He reiterated the idea that he had no faith in doctors. He became impatient at home, uncertain, moody, irritable, and difficult to get on with. One day he made a few superficial scratches on his wrist, but later said he had not the courage to commit suicide, and/

and that he wanted to live since he was keenly aware that he had a wife and two children. He became rather religious, requesting texts and reading the Bible extensively.

On the day of his admission to this hospital his wife found him in his room with the door barricaded and the gas fire on unlit, but with the windows wide open. He was not in a serious condition.

When admitted he was co-operative but, after some time, and usually during the night, he would throw himself from his bed on to the floor. On one occasion he hurt his head. On being questioned he said an attendant has assaulted him - first with a fender, and then with a poker, and that he was hated by everyone. When he was given paraldehyde he shouted that he was being poisoned.

There was no formal disorder in his mental stream. His affective response showed the normally expected variation and was usually appropriate. It was predominantly depressive and suspicious.

He was always suspicious in his attitude, particularly in relation to the treatment he was to be given. He would say: "Get it over - whatever you are going to do". He distrusted all sedatives and felt unsafe under their influence. He asked why he had been brought to hospital - denied that he needed treatment, and demanded to be "released". On occasions he believed his wife to be speaking to him in the hospital when, in fact/

fact, she was nowhere near. He was convinced that everyone was against him, and that they would even murder him.

Memory, orientation and retention were excellent. His capacity to think and to attend were unimpaired. Intellectually, he was well-preserved. He had but very slight insight into his condition.

A month or two later he kept shouting for his wife, whom he was convinced was in the building and "being immorally used". He insisted on leaving hospital without delay.

He showed very definite hysterical phenomena; he would fall down on the floor as if in a fit, but he was not unconscious, and when carried back to bed would moan that he wanted to leave hospital. He gave notice of his intention to leave but withdrew it. He insisted that the medical staff were bent on "doing away with him", and demanded to see a Judge who would "assess the fairness of such action". In August, 1944, he jumped from 13 ft., explaining that his wife would be better off without him. He sustained a fractured patella. In september he wrote to his wife saying that it seemed that in this hospital he had to perform prodigious feats of acrobatics and to injure some other part of himself. He went on to say that it seemed that some Authority had elected to give him a test or found him wanting, or else he had injured all their families; he stated that he/

he never wanted to hurt any of them but that seemingly he had been a donkey and must take the consequences. He hoped that none of his family would be drawn into the plot, although he feared that had happened already.

By the 1st February, 1945, there had been a slight improvement but he was still undertain and emotional. In April he was still regarded as potentially suicidal and continued to express many paranoid delusions. He insisted on giving his notice to leave, and then withdrawing it every few weeks.

In October, 1945, his condition was unchanged. He was very suspicious in his attitude - he talked of being poisoned; he attributed some loss of weight which was taking place to the Staff, and considered there was a deep and complex scheme afoot directed against his wellbeing in which all the doctors and nurses were involved. He made veiled insinuations about the Gestapo and about the doctor "obeying his instructions". He made reference to noises coming through the walls and was undoubtedly hallucinated. He talked in terms of poison gas being pumped in above his bed.

After an illness of at least four years' duration this patient continued to express delusions of a rather bizarre, poorly-systematised and changeable nature; e.g., that his wife is in the hospital and is being used; that the doctors and nurses have evolved a complex scheme of persecution, which is being directed against/

against him; that the Gestapo is instructing the doctor, and that strange noises come through the walls. Hallucinations are present. There is no disconnection in his talk. At times he is facile and smiles whilst telling of his delusions but, for the most part, his affect is in harmony with his behaviour and talk. He shows periods of depression with the expression of depressive thoughts, but these are short lived, and are soon replaced by the predominant suspicious, insinuating attitude, in which he demands to be released and makes veiled references to schemes of persecution. His intellectual faculties are intact. Physically, there are no abnormalities. His interest is alive and he is able to conduct physical training classes for his fellow patients. He took an active part in the organisation of the Annual Sports. Mannerisms, stereotyped behaviour, and faulty habits have not been seen. The lapse of four years has produced little change in the patient's condition. The personality is well-retained and mental deterioration, with the characteristic dullness and indifference of the Schizophrenic, are absent from the clinical picture.

CASE NO. VIIIS U M M A R Y

This was a shy, sensitive and conscientious youth, with an excellent scholastic record, who broke down at the age of 22 years with an illness characterised by fantastic delusions and auditory hallucinations, predominantly persecutory in nature. There was a depressive colouring to the picture. At one stage, his behaviour showed a severe degree of regression, with refusal of food, double incontinence, and monosyllabic talk. Yet, on the whole, there was little disconnection in his thought and, at the height of his illness, he was able to write an excellent and coherent account of his interpretation of his experiences. He was correctly orientated, his memory was unimpaired, emotional blunting and incongruity of mood, thought and behaviour were not prominent. After an illness of over two years' duration, which had not responded to electric convulsion therapy or insulin, leucotomy was carried out - a satisfactory result was obtained, and he was able to leave hospital.

C A S E H I S T O R Y

J.L. - aet 22: There was a bad family history, indicative of nervous instability. The maternal and paternal great-grandparents were alcoholic; the maternal grandparents were alcoholic; the maternal grandfather committed suicide; a maternal grand-uncle was an alcoholic and a drug addict; the paternal grandmother/

grandmother was quick-tempered; a paternal cousin committed suicide, and a paternal aunt had a nervous breakdown of an obscure nature. The mother had two depressive illnesses; the father was a nervous man - but no nervous illness occurred. The mother and father were second cousins.

There were four offspring - the first and second were stillborn; a sister followed, who has been certified as nervously unfit for military service; the patient is the younger living sibling. The birth was normal; he was a placid, healthy child. There was no history of bedwetting, nightmares, or special fears. At the age of four he came under the guidance of a Governess who, apparently, dominated the domestic scene, so that he seldom felt the influence of his mother. The father was a man in his fifties and the patient felt little contact with him. At the age of six he went to the local school, and disliked it. He was rather timid and did not associate much with other boys. At ten he proceeded to a bigger school; he did not mix well, and had but a few friends. He was extremely sensitive - inclined to be shy; conscientious, and careful with his money. He was a keen reader. He was resentful of what he thought was maternal over-protection, and felt his initiative and enterprise stifled. He suffered from blushing attacks. Later, he adapted himself better to school and enjoyed it. He was an excellent scholar and a good elocutionist; he was fond of music, and he played golf and tennis. He distinguished/

distinguished himself in his school examinations, and proceeded to University. There, he became less shy and more sociable. He joined the O.T.C. and passed his Certificates.

Early in 1942 he was called up. He was commissioned in May, 1943. In the same month he was involved in a severe air-raid, and had to supervise the evacuation of a building. Following this, he became nervously ill - complaining of fatigue, headache, frequency, testicular sensations, and impairment of concentration. He was admitted to hospital, where he improved, and was discharged in the course of a few weeks. He was reported as being schizoid and mildly unstable, hypochondriacal, and slow in thought and action; unsuited to lead men and for Foreign service, and requiring observation.

After five weeks' home leave he was posted to another Unit. In December, 1943, he began to think that people were plotting against him; he thought the men were about to attack him, and so he locked himself in his room. He set fire to some articles, as a beacon to the surrounding countryside, in the hope that help would arrive. He ate and slept badly; he was nervous and excited. He possessed a revolver and a grenade and was potentially dangerous. He was transferred to a Military Mental Hospital.

On admission he was excited, deluded and hallucinated; voices called his name and said he had vene-real/

venereal disease; the wireless was fixed so as to fire a bullet into him. His food was poisoned. Electric convulsion therapy proved ineffective; he continued to be violent and aggressive, and to voice persecutory ideas.

In January, 1944, he was reported to be suffering from an acute schizophrenic reaction, with changing delusions and auditory hallucinations. He was admitted to a hospital in Edinburgh in February, 1944. His physical condition was satisfactory. He lay in bed brooding and deep in thought. His affect was predominantly one of sadness. He insisted he was a traitor and about to be killed; that the country, the Army, and his people had been let down by him. He said he did not want to get better and would never improve. There was a slight improvement in April and May, but thereafter he got worse. He was very depressed and spoke to no one. In January, 1945, he wrote his experiences, which indicate his mental trends and the coherence of his thought.

In this document he writes of the period "before the net was closed around me". He stresses his reluctance to join the Army, and tells how he obtained postponements and felt that this led to "my being watched thereafter wherever I went". He was continually found fault with and made conspicuous; he was specially chosen to be made a fool and a laughing stock of before others. He felt he had exasperated the Secretary for War, and that/

that "preparations for putting me through the engineering process would have to be made". Describing his transfer to a new Unit, he said "No sooner had I arrived than I realised that as expected the organisation had been to work and I was again under observation". He wrote of a man detailed to watch him, who smoked scented cigarettes. He thought that this was done to incite him to frenzy. He pointed out that cigarettes were called "cigs" in the Army, and deduced from this that the Chief of the Imperial General Staff (C.I.G.S.) must have "been in the know". He thought he was being mesmerised. He thought he was to be killed and heard a voice whispering "torn asunder - limb from limb". He thought the staff tried to make him believe that the hospital was immoral sexually and homosexually. He felt he was asked to believe that three men had had homosexual relations with him . He wrote of "sexual relations with a Sister, unperceived physically".

The above document showed no irrelevancies or disconnection, and indicated how well-retained his mental processes were, although based upon delusional ideas. A month after writing it his physical and mental condition became more serious; he lost flesh; became resistive; sucked his fingers; spoke in monosyllables, and attempted to injure himself. He was doubly incontinent, and tube-feeding was necessary.

Leucotomy was carried out in July, 1945. The improvement/

improvement was striking; even during the first post-operative week his face had lost its tenseness; he was alert and interested; he could do intricate mathematics; he behaved in an easy manner without showing facility. Paranoid trends remained, for he felt the less he said to the medical staff the better for safety reasons. He persisted in the idea that he had previously refused food because it was poisoned. During the fourth week he made great progress - he gained in weight; he denied hallucinations. In November, 1945, he was discharged. He was happy, interested, and active - eager to take up work. He lacked insight, saying that he would have got better without an operation, and that he was never really ill. He was certain that in the Military Mental Hospital they tried to kill him. He would not say that his food had not been poisoned; nevertheless, he gave no spontaneous expression to his delusions, and he appeared in the eyes of his fellows as a normal individual.

Nine months later it was reported that his mental condition was less satisfactory. He had taken out Geography Classes at the University and had scored only 45% in his Examinations. Nevertheless, he remained confident in his abilities. His one ambition was to earn a salary and to get married, but he seemed unable to apply himself to these ends. He became interested in religious matters and factions. At present he is attending the Out-Patient Department, and he is being advised and persuaded that he should limit his activities and direct his attentions to his immediate future.

CASE NO. IXS U M M A R Y

A suspicious-minded, stubborn, aggressive individual whose illness started insidiously with ideas of reference, delusions of a persecutory and grandiose nature, and auditory hallucinations. Episodes of extremely assaultive behaviour followed. There was at times a certain diffuseness of talk, and always a total lack of realisation that he was ill mentally.

C A S E H I S T O R Y

J.R. - aet 25: This patient was admitted from Orkney to the Royal Edinburgh Hospital for Mental and Nervous Disorders in September, 1941. There was no history of nervous or mental disorder in the family. The patient was an illegitimate child. He was brought up by his grandparents. He attended school from 5 to 14 years, and was described as an average scholar, who mixed well with others and took part in games. He was never shy of girls, but had always a suspicious feeling that he was not accepted in a normal way by his neighbours. He denied any feelings of diffidence however.

On leaving school he worked on his grandfather's farm and this was made over to him when he became 21 years of age. He was an efficient worker, but always had the idea that the Orcadians regarded him and his grandfather as strangers, since his family originally came from Perthshire. Reports obtained from a psychiatric social worker in Orkney failed to confirm his suspicions/

suspicious. Shortly before his admission he thought his neighbours were plotting to take his farm from him; that they wanted him out of the way because he "had something on them", saying that he would produce evidence to incriminate them for evading Customs regulations. He was accused of molesting the local minister's maid and of entering her place of work without authority. This he admitted but believed he was entitled to do so.

He had false ideas about a so-called right of way on his farm and was violent to Islanders who used this path. All his neighbours bore witness to the fact that he was sullen, depressed, and abnormal in his actions and ideas.

On admission he protested his sanity. He was not immediately violent, but was suspicious of everyone and at all times hostile in his attitude. He declared that the Doctor who certified him did not try to understand him and did not like him anyway. He kept demanding to be sent home, saying that he was innocent of any crime and perfectly good in body and mind. He tended to be rather stereotyped in his talk and continually spoke of his persecution by his neighbours. He felt they were plotting to eliminate him. He was occasionally rather diffuse in his conversation. He was suspicious in his bearing and regarded the staff as being people in whose presence he should proceed with caution.

Shortly after admission he began to write letters to the medical staff and, later, addressed his lengthy/

lengthy epistles to those in high office at the Admiralty and War Office. His letters, which took a rather stereotyped form, dealt with many and varied contrivances he had invented for the better prosecution of the war. These inventions were obviously the product of a deranged mind. His delusions in regard to these were numerous, variable, and contradictory. He invented a machine which would prevent German Bombers crossing the British coast line. Thus, he wrote: "I have a scientific discovery for the efficient destruction of raiding planes - it is imperative that it be in Government control at a very early date as no person can develop this for me, the secrets being in my brain.....large areas could be defended at minor expense and much more efficiently than A.A. guns or barrage balloons or fighter planes.....I have more important inventions both naval and military...they do not have to be developed mechanically before being sent to the Research Department. There are also business affairs and a 300 acre farm at home.....scientific discoveries that I know of are several and I can prove what the aurora borealis is".

This tendency to write to persons of position and authority increased and the patient became more grandiose, until he believed that the war would drag on endlessly unless the authorities availed themselves of his deadly arial mines and special torpedoes. When his attention was drawn to the fact that he was writing these letters without permission he suddenly gave up the/

the practice and apparently decided not to mention his inventions again.

As time passed he seemed to have settled down to life under hospital conditions and worked usefully in the gardens and the piggery. Nevertheless, he took every opportunity to protest his innocence and victimization. His delusions continued with little systematization and with numerous additions. He frequently expressed delusions regarding the female nursing and clerical staff, whom he thought were interested in him and desirous of his love. To these girls he wrote letters arranging meeting places and he several times threatened other patients whom he believed to be interfering in his imaginary love affairs. In one particular instance he made a very serious attack upon a fellow patient. It appears that on this occasion imaginary voices hurled abuse at him which he considered emanated from this patient and, on the basis of this, he made a homicidal attack. He always wanted to be the top dog and felt himself superior to others.

He was at all times correctly orientated and well retained in his recent and remote memory. Retention was unimpaired and grasp of general knowledge satisfactory.

During the four years the patient was under care here his condition showed little change. Remissions were not seen. Episodes of excited and assaultive behaviour persisted. Unsystematised, variable, and transient/

transient delusions of a persecutory and grandiose nature were prominent, and accompanied by hallucinations. Memory and intellectual faculties remained at a good level and the personality was well retained.

After four years, when the patient made a serious and unprovoked homicidal attack, arrangements were made for him to be charged, and he was later transferred to H.M. Criminal Mental Hospital.

Throughout, his physical condition remained satisfactory. He was a well-developed man of excellent physique.

CASE NO. XS U M M A R Y

This was a capable, conscientious and sensitive girl whose work record was satisfactory and who had handled her responsibilities adequately. She was very much attached to her mother and sister and had no interest in men. About the age of 28 years she gradually developed delusions and hallucinations of a persecutory type which became more fantastic as time went on. She grew suspicious-minded, irritable and aggressive and was given to frequent outbursts of bad temper. She accused her sister of trying to poison her. This sister was aware that the patient took less interest in her personal appearance but such a change was not noticeable to casual observers. Her illness has taken a fluctuating course, but her delusions and hallucinations have persisted although they have not always been expressed. After three years there has been little change. On examination she is usually composed and gives a reasonably good account of herself, but her suspicious-mindedness and evasiveness are frequently noticeable. There is no disconnection in her thought, her emotional response is appropriate, orientation memory and general intelligence satisfactory. Mental deterioration has not taken place.

C A S E H I S T O R Y

W.S. - aet 28: A family history of nervous or mental illness/

illness was denied. The mother died in 1935 of "heart trouble". The father is alive and well. The patient came second in a family of three girls. The early situation at home was said to be happy and satisfactory. Apart from the mother's continual "heart attacks", which put a strain on them all. No neurotic traits were noticed in childhood. She went to school from five to fourteen years, and was described as probably an average scholar although certainly not above average. On leaving school she stayed at home and looked after her invalid mother.

It was said of her that she was capable and sensible and that she had a lot of domestic responsibility - both before and after the mother's death - but with this she was able to deal adequately. She was smart in her appearance and house-proud. She was anxious to better herself, particularly in the sphere of education, and read a great deal. The family as a group was sensitive and the patient was no exception. She was easily hurt and if ~~anyone~~ said an unkind thing to her she brooded about it for a long time. If she did not feel well she would never tell anyone; she kept her feelings to herself, and confided in no one but her sister. She got on well enough with people in a superficial way, but her circle of friends was small and she was rather unsociable. In company she often felt tense and became easily flustered. She was not subject to swings/

swings of mood. An attitude of suspicion and jealousy was not at this time noticed. She was deeply attached to her mother whose death came as a great shock. There was also a strong attachment to her younger sister ,and they are described as having "mothered" each other. She never took up with men and, as far as is known, never had a boy friend . She said she could not be bothered with them.

In 1940 the patient joined the Auxiliary Territorial Service and her sister the Women's Auxiliary Air Force. She got on well enough until 1943 when she was posted to England from Scotland. She was through several air raids, but does not think she was unduly perturbed, although she admits to feelings of nervousness on some such occasions. About this time, however, she formed the impression that people were looking at her antagonistically and laughing at her. She developed pains in the back and the abdomen. Her previous sensitiveness became more marked. She felt she was being watched but no one would explain this "observation" to her, and she was told that she was imagining things. She decided, however, that it could not altogether be her imagination and yet there was no reason to explain it. She tried to treat the matter with indifference, but annoyances continued; "silly looks, bad looks, sniffing, and coughing" were directed against her as she passed people, in an effort to draw her attention to something . She thought that people were making insinuations/

insinuations about her and inferred that they were of the opinion that she had misbehaved herself sexually. She felt that people watched her, and said that this made her awkward in her actions.

She had mild sore throats and the discomfort in the back and abdomen persisted. At first, she attributed the abdominal pains to indigestion and dismissed them as trivial. As time went on, however, she noticed that the pain was aggravated by eating and drinking and she deduced from this that probably her food was being tampered with. She thought the Army might be responsible, but was in some doubt. The "observation" of her continued and she supposed that this might have been due to the fact that "one is more conspicuous in uniform".

She mentioned her ideas of reference and her bodily discomforts to the medical officer and was admitted to hospital. Soon afterwards she was invalided as a case of neurosis - no pension was awarded.

Immediately after discharge she obtained work as a governess from May to September, 1945. She felt happier but had several attacks of pain and vomited on three occasions. She gave up work to stay with her sister on the latter's demobilisation, but as this sister wished to be in the south near her boy friend, this arrangement broke down. Following this, she worked for a while in domestic service, but later her sister returned to Edinburgh and they went into lodgings together/

together . The patient obtained employment as a leather worker. From that time both the pains and the delusional ideas increased.

To the sister it was clear that a change had come over the patient. She lost her temper quickly, she was irritable, and she fancied that everybody was against her. She had frequent outbursts of temper in which she accused her sister of incredible things. At night she lay awake - apparently brooding. She did not take the same pride in her personal appearance as was her former habit, but this was noticed only in small ways; thus, she allowed heels of her shoes to wear down, and she did not attend to her hands and fingernails. In all other respects, however, her personal habits were satisfactory. She refused to make friends, saying that they would only start telling lies about her. She blamed people for tampering with various articles of diet; she told her sister that she had interfered with a bar of chocolate, and it was this which caused the pains in her stomach. She thought the water was interfered with and also the jam, and yet she would go on eating as if nothing had happened. She accused her sister of trying to poison her.

She said that somebody in the Air Force was involved in a scheme to try to kill her. Aeroplanes which chanced to fly overhead she thought might be influencing her and producing the pains; she was under the impression/

impression that in the streets and in tramcars people looked at her strangely. She thought her employer was accusing her of telling lies and of writing anonymous letters. She would get up through the night and walk about the house smoking cigarettes.

She had little insight into the nature of her illness. After she had eaten certain things she felt jumpy and nervous - sometimes violent pains resulted, which she thought affected her general health. She admitted to auditory hallucinations of a persecutory kind. She also had nightmares and bad dreams in which an unknown person seemed to be pushing her from behind over a precipice or out of a train. On admission to Jordanburn Nerve Hospital in August of 1946 she was able to give a satisfactory and coherent account of her previous history. She was, however, on the defensive and a suspicious attitude in relation to the doctor and the other patients was prominent. She did not mix much with the others and, from time to time, openly accused them of interfering with her. On the whole, however, she was co-operative with the staff. Her emotional response was appropriate. There was some disharmony between thought and behaviour, for she would take her food although believing it to be poisoned. There was no disconnection in her thought. Her memory, orientation and general intelligence were satisfactory and, after an illness of three years' duration, mental deterioration was not a noticeable feature.

No abnormalities were noticeable on physical examination.

CASE NO. XIS U M M A R Y

This was a conscientious and apparently well-exteriorised man who, nevertheless, was sensitive, hypochondriacal, and jealous. He had an excellent work record, including 21 years' Service in the R.A.F. He broke down at the age of 38 years with an illness characterised by delusions and hallucinations of a bizarre and poorly-systematised nature. After at least 16 months his symptoms persist, but his personality is excellently retained and there is no evidence of mental deterioration. His general attitude and behaviour give no indication of his mental involvement. He has little real insight into his condition.

C A S E H I S T O R Y

E.G.S. - aet 38: This patient was born in Exeter in 1906. He came second in a family of four. The rest of the family are alive and well. The mother is described as "extremely nervous" but, further than this, there is no admitted family history of nervous or mental disorder.

The early situation at home was satisfactory enough, but the patient felt that he was always blamed for any misconduct that occurred, so that he developed an "inferiority complex". Thus, he said, his mother always used to hold up his father's homecoming as a threat, so that he came to hate the very sight of him. In later life he tried to alter his attitude towards his/

his father and now they get on well, yet it is a sort of respect for him born of fear. As a child he was described as a 'little devil', yet he was at the same time timorous, particularly in regard to his health, and on one occasion when he noticed his thumb blue after a minor accident, he thought it was poisoned and became very afraid. He attended school from 5 till 14 years and was an average scholar. He was conscientious and never truanted. He was afraid of the dark and of heights. He was sensitive and very ambitious. He was afraid of bullies. Of this period he says: "There was always something in me that was frightened all the time." A funeral, for example, would impress itself on his mind for days. He was a boy who liked his own way. He said that he could never talk over any difficulties he might have with anyone lest he might be laughed at and ridiculed. Certain unhappy childhood memories have lingered in his mind to the present day. Thus, when he was 10 years old he remembers a boy fell from a tree and bled his ears - this he has never been able to forget. He tended to be rather self-centred.

On leaving school he worked for four years as an errand boy. He describes how he thought he had strained his heart while cycling and he has never been able to throw off a fear of heart disease which originated then.

In 1924, at the age of 18 years, he joined the Royal Air Force being influenced in this direction by his/

his father who was serving at that time. He liked the Service and got on well with his comrades. He joined as a cook but was not keen on this work. He was eager to better himself. After some time he was promoted and eventually he became a warrant officer attached to the Catering Department. He was later commissioned as a catering officer and at the time of his discharge in 1945 held the rank of Flight Lieutenant. He was first posted abroad - to Aden - in 1930 . He liked it, but his thoughts frequently turned to his heart; he feared it would stop and that he would die. He tried to forget himself and to take interest in other things, but the more he tried to do this the more his attention seemed drawn to his heart. He tried to prevent himself hearing his heart beats at night, but slept badly. He was never really happy on account of these worries.

While abroad he swam, played tennis, joined in other activities and, generally, tried to put on a good exterior, but he felt unsettled and wished to get home. He was often very upset about what he calls his 'obsession'. He knew his heart was all right, and yet he could not disabuse his mind of his fears.

Before proceeding overseas he had married, and he became suspicious and jealous-minded about his wife at home. He had extramarital sex relations, always associated with feelings of guilt and wrongdoing.

He was posted home for two years and, after a further period of Service overseas, he was continuously in/

in this country from 1938 till 1945, during which time his wife was able to be always with him. He was commissioned in 1941.

At this stage his personality was described as follows:- He was over-conscientious in regard to his work, which had to be completed to his satisfaction irrespective of time. He was more generous than thrifty. He was fastidious in regard to his personal appearance and arranged his day meticulously and worked to a routine. He was a moderate drinker and was sociable in company, being more at home with men than with women. He was, nevertheless, popular with girls but inclined to be shy and sensitive in their company. His wife thought that he was too conscientious in regard to his work. Mood swings were not a noticeable feature. He was, however, jealous and this trait became more pronounced after he was commissioned. At parties he watched his wife carefully, suspecting her of encouraging other men, and afterwards he would challenge her without reason so that arguments and unpleasantness ensued. He admitted that he made things unpleasant for his wife by this attitude, but said he could not help it. In the mess he suspected his brother officers of making advances to his wife, so that she had to stop going there. It was confirmed that he had no grounds for his suspicions.

He was drafted to India in May, 1945. He was not anxious to leave home but seemed to resign himself to the idea. Shortly after his arrival there he reported/

reported sick "with nerves". He complained of palpitation, and fears that his heart would stop. He manifested anxiety as to his ability to sweat and was very frightened about his physical condition. He was described as a colourless man who did not respond to explanation or reassurance - a chronic neurotic, who had carried on quite well as far as duty was concerned, but was now losing whatever power of adjustment he possessed.

He was accordingly repatriated in October of the same year, and demobilised as a Class 'A' release in January, 1946.

On his return home his wife did not notice much amiss, but thought he was rather quieter than usual and noticed that he brooded a great deal. He slept badly. Gradually his condition became worse and he was referred to Jordanburn Nerve Hospital for out-patient treatment.

He said that for a period after his return he felt very depressed - he thought people were taking undue notice of him and staring at him. Every time he went out he had urges to throw himself under vehicles. Voices kept saying "What's the use".

A sample of his spontaneous talk will indicate his mental trend when he was admitted to Jordanburn Nerve Hospital in March, 1946:- "Just as I was entering hospital a voice said 'don't go in' and called me a silly bastard. When I am going to kiss my child a voice says 'don't kiss her'. I see myself in the most hideous form/

"form - inside my eyes somehow, as though I'm seeing my brain in a cavity.....Last night I was awakened by a pair of eyes which seemed to be isolated and yet belonged to me - they travelled all over my body. At the same time a high-pitched, whistling took place in my head, and this was accompanied by muscular twitchings of my body.....I felt I was struggling with myself and people were staring at me for this reason.....I feel I am being persecuted....my subconscious is frightened because in a dream it appealed to me for help...Whatever I did - pulling out my handkerchief or coughing - is duplicated by my subconscious. A voice threatened to stop my breathing. I have tried to figure all this out - it is not imagination. It started when I was in opposition to the beating of my heart over a year ago". He felt he was up against some unseen enemy against which he must struggle so that its influence would become weaker.

He thought he had a dual personality - one, his subconscious self, he supposed, laughed and jeered at him and, when he shaved, it told him to cut his throat.

On another occasion he said he had seen three pairs of eyes, and when he wakened in the morning he found that he fitted into the top pair. The more tranquil centre ones seemed to be attracted to his subconscious mind. The lowest ones were those which he fitted into before the struggle began. He went on to say: "If I fit myself into the top pair I find my will-power is nil. I try to fight the second pair - the lower pair/

pair of eyes represent me with full will-power, able to overcome the influence of the middle pair."

Physically, this patient was in excellent condition. He was of average size and of good muscular development. The blood Wassermann was negative.

His personality is maintained at a high level. He is pleasant and frank in his attitude. He is co-operative in his treatment and employs himself usefully in the hospital. He expresses his ideas to few apart from the doctor. His memory and orientation, and his grasp of general affairs show no impairment. He is a man of average intelligence. He has, however, a tendency to sit from time to time with his eyes closed, although not asleep, and he does this while striving to master his thoughts, and to overcome the strange influences which seem to have obsessed his mind.

He is cheerful and bright in his mood and, at times, shows almost a mild elation. He realises to some extent that he is in need of help, but his insight is very incomplete, for he is unable to accept the suggestion that the phenomena which he describes are not in fact real, but prefers to attribute them to some "strange foreign body" which has taken control of his mind.

Thus, after an illness of at least seventeen months' duration, delusions and hallucinations of a bizarre nature persist, although depressive symptoms have disappeared from the clinical picture and no physical infirmity exists. The affective response is appropriate/

appropriate for the most part, and his frequent cheerfulness is in harmony with the idea that he is winning the struggle with his tormenting experiences. The personality is retained at a good level, and mental deterioration is strikingly absent.

CASE NO.XIIS U M M A R Y

This was a man who had been severely handicapped throughout life by a very high degree of myopia and congenital cataract. Serological tests for syphilis were negative, there were no syphilitic stigmata, nor was there a family history of this disorder. He was of a sensitive and suspicious nature and, when first seen at the age of 35 years in 1937, he expressed numerous bizarre and fantastic delusions. His personality, however, was well retained and home circumstances allowed of his being cared for there. In 1941 he became more involved, and was admitted to hospital as a voluntary patient. He remained for four months and was able to return home again, although his delusional trends persisted. He continued to be seriously involved mentally, but his personality retention and lack of mental deterioration were remarkable, and it was 1945 before he again entered hospital - this time as a Certified patient. Although unsystematised, strange delusions were expressed he showed none of the usual late schizophrenic stigmata nine years after the onset of his symptoms. There had been little progression of the condition and little to indicate mental deterioration.

C A S E H I S T O R Y

W.F.H. - aet 35: The father was a German. He was an intelligent and level-headed man and employed as a language/

language master. He was repatriated in 1914 and was thereafter unheard of. The mother, who was said to be a cultured and sociable woman, died aet 75 of cancer.

The patient was the youngest of three siblings. The elder son entered the Civil Service and was described as a domineering, managing type. In childhood he bullied the patient. The sister, who was a stable personality, was employed as a dressmaker.

There was no family history of nervous or mental illness.

As a child the patient was sensitive and shy, but generous and open-hearted. He had few friends - partly on account of his defective vision, which made it difficult for him to join in games, etc. He was domineered and bullied by his brother. He was strictly brought up. He went to a good school and there he managed to get on well enough despite his defective vision. His memory was excellent. At the outbreak of the last war, when his father returned to Germany, the patient was teased so much at school about this and was made so miserable that he had to be taken away. He went into an office and later had other miscellaneous jobs, but never remained at any of them long - ostensibly because of his eyesight. He did not like using his hands and no attempt was made to train him for any semi-blind occupation. It was remarkable, however, that he was able to write articles and even review books. He liked/

liked reading, but could only do this for short periods at a time. For some years before his illness the patient had not gone out to work, but helped his mother in the house and indulged in his literary pursuits. His attachment to her was very deep and, as her health deteriorated, he did more and more for her. He got on well with his sister's friends and other young women and, in fact, he was rather exclusively shut up with female society. He never went out with girls.

To his sister he appeared normal until the age of 35 years, when his mother died. He did not react with much overt emotion at the time, but seemed to lose all sense of security. He worried about the division of his mother's property. He thought his brother and sister were trying to defraud his late mother or himself. He turned against his sister, to whom previously he had been devoted. He told outsiders that she was spending his mother's money. He wrote vicious letters to the family lawyer. In 1937 he was seen at Jordanburn Nerve Hospital and received Out-Patient treatment. He improved a little but after some visits refused to return. At that time he gave a clear account of himself, and others described his personality as being shy, sensitive, solitary, and suspicious-minded. He easily lost his temper, was uneasy in company, and highly introspective. His myopia and cataract were noted. He suffered from a number of delusions, saying that messages were being sent to him over the wireless; that an X-ray machine had/

had been placed on the roof, so that his actions might be observed. He stated that on at least four occasions, whilst out walking since his mother's death, he had seen her. He suspected his sister of eavesdropping outside his door. Although little hope was pinned on psychotherapy, the patient was encouraged to take a more detached attitude to his difficulties. His personality was extremely well retained. His people were willing to continue with him at home, and it was thought that at this stage mental hospital treatment might restrict his activities and make him worse.

After this he showed improvement for some months, but there followed again an increase in his irritability and suspiciousness. Noises - especially the water system - annoyed him. He thought taps were turned on in the flat above to test him. He accused his neighbours of following him to the bathroom. He developed a craze for patent medicines - determined to get something to help his eyes. His relations with his sister deteriorated - he accused her of wanting his money. He said he was being persecuted by all, especially by doctors and the police. He thought the house was wired for television. He felt everyone knew what he said. He told his sister she was responsible for air-raid alerts and for street noises. He was auditorily hallucinated. He said the whole world was against him.

At/

At this time he believed himself to be sane, but was persuaded to sign voluntary papers for his admission to hospital. Having done so, he said: "Fancy a sane man going into an Asylum".

In hospital he was extremely suspicious. Nevertheless, he talked a great deal with patients and staff, and was well-behaved. He ate well and slept soundly. There was no formal disorder in his talk, but there was pressure behind it. He answered readily and coherently. He tended to indulge in rhetorical multiplication of nouns: "When I look back on it I feel everything connected with mother's death was unreal - a show - a counterfeit." His emotional response was sharp and, at times, the impression was gained of mild elation. He said he had never talked much about himself to anyone: "Everything was pent up inside me". His thoughts were rather mixed. While at first he reiterated his delusional ideas, later he said he had taken everything the wrong way - that people were really trying to help him when he thought they were determined to do him an injury.

He said that some months before his mother's death he felt outsiders thought he was taking her money. He heard the banker say to his clerk: "he is robbing her". This made him very suspicious and annoyed. He said that he thought his mother was alive and that it was unfair that she should be kept out of her own house/

house because of something that was wrong with him. He said that he had seen her in the street and at the Bank but, because of his defective vision, she was past before he realised it. In a picture house he had the idea that she came in after him: "It was a sort of sixth sense". He felt the whole thing was what the Americans call "a frame-up". He said a man with a homburg hat and grey coat followed him and created obstacles for him.

He said he masturbated until the age of 30, and had nocturnal emissions which he worried over and which he thought would result in meningitis.

He said he was two people in conflict. One was aggressive - the other willing to help. "I spent all my time looking after my mother and sister, and when people started following me and talking about me I began to think that looking after one's relatives did not pay, so two people developed inside me in conflict and I am the spectator. They talk to each other and I often sit back and watch good and evil having a real scrap with one another. They come and go in my head like St. Joan's visions - one seems to come from the world of commerce, whilst the other is the owner of a harem. They have separate lives outside myself - they have separate houses. I can picture the harem in Arabia".

His school and general knowledge were satisfactory, his orientation correct, and memory unimpaired/

unimpaired. He developed a degree of insight into his abnormal ideas but, on the whole, remained convinced that many of them were correct. Mental deterioration was absent and to the uninformed he appeared normal.

His delusional ideas remained little changed, and he told the doctor casually one day that before he came to hospital he felt a kind of influence emanating from it. There was at times an abnormal shallowness of emotional response.

He was discharged at his own request, still far from well, but anxious to do work of National importance.

During the next four years he remained at home and did odd jobs. He expressed his delusional ideas, but never became violent or aggressive until shortly before his next admission. He showed few anomalies of behaviour.

In 1945 his condition became worse. Aggressive and suspicious behaviour disallowed of his continuing at home. He was accordingly re-admitted on Certificates. He expressed similar delusional ideas and was auditorily hallucinated. There was noted again a certain pressure behind his talk, and a mood of mild elation intermingled with his suspicious and aggressive attitude. His personality was well-retained, however, and after an illness of nine years there was little to suggest mental deterioration.

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